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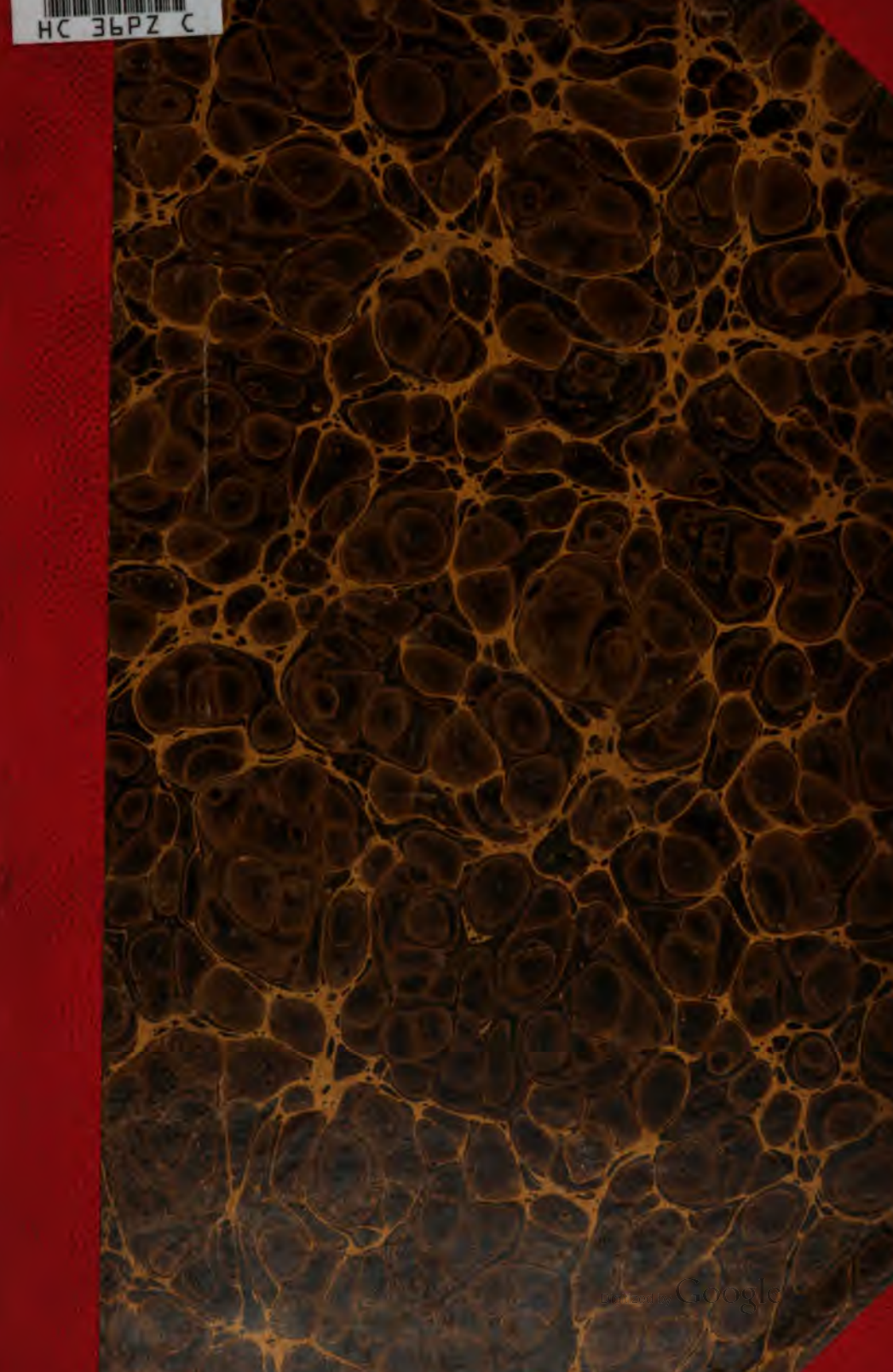

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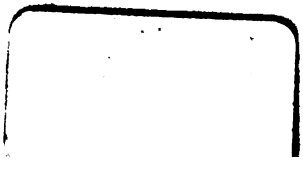

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MEDICAL REPORTER

A Monthly Epitome of Medical Progress.

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THE WESTERN
MEDICAL REPORTER

VOL. VII. CHICAGO, JANUARY, 1885. NO. 1.

Medicine.

Edited by WM. E. QUINE, M.D., 3151 Wabash Ave.

Report on Medical and Surgical Electricity—Galvanism.—DR. MAX BUCH has called attention to the fact that galvanic irritation of a living muscle always produces an increase of temperature, and has, in this connection, proposed to apply electricity to determine the truth in cases where death is not certain. Although muscular contraction can be produced for a short time after death in certain portions of the body (the deltoid, or quadriceps femoris), no elevation of the temperature occurs after five hours, and he therefore proposes the conjoined application of a delicate surface-thermometer, with the current from, say, five cells. When the mercury has remained stationary for some minutes after applying the thermometer the current is turned on, and at once the column rises in the tube if the muscle is alive, but if death has occurred the temperature remains unaltered. The method may, at rare times, be of value, but other very good indications of death are within reach of practitioners of ordinary skill.

Gibney reiterates, in the New York *Medical Record*, the advantage of the *strong* galvanic current in obstinate sciatica. He applies the positive pole over the nerve at its point of exit at the sacro-sciatic notch, and the negative is placed just above the popliteal space, or, preferably, over the area of greatest pain. The current is run up to its maximum bearable force and kept there. Referred sensations (paræsthesia) will now be felt throughout the distribution of the nerve. The pain is never so bad from the current as from the neuralgia, and relief is usual from the first. Great care must be observed in precision of application. Cases are given in illustration, and we know from

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experience the value of Dr. Gibney's method; and our own observation agrees with his in several obstinate cases where every other method of treatment failed.

The galvano-cautery has been lauded by Frolich, of Berlin, in follicular catarrh and trachoma. The reaction is stated to be slight, even when extensive granulations have thus been destroyed.

The cautery has also been quite successfully employed in lupus by Bernier (*Paris Medical*), and Shoemaker of our own city. One great advantage over jequirity and ordinary caustics is the almost entire absence of acute pain, and another is the decreased probability of auto-inoculation. The incisions usually made by the bistoury have without doubt, been the means of extending the disease, when carelessly made. It is asserted that the latter procedure has, before now, been the cause of lighting up internal tuberculosis, true lupus being, according to Cornil, a tuberculosis disorder of the skin. This theory has received support from good authority at late medical conventions, and if the cautery can compete with older methods of destroying the local affection, which is reasonably certain, the advance in therapeutics is an important one.

The troublesome senile hypertrophy of the prostate is, according to Bredert (*Berlin Klin. Woch.*), rapidly reduced by electrolysis, the cathode being applied to the gland by insulated needles. Five cases are reported as thus cured, but the account given does not state whether the reaction developed any inflammatory sequelæ. In our own cases, where the ordinary current has been applied *without puncture*, we have repeatedly had to combat considerable irritation of the bladder, though, curiously enough, galvanism has, at times, relieved cystitis promptly which arose from other causes.

Galvano-Puncture in Aneurism of the Aorta.—Dr. Francesco Brancaccio reports the case of a man, intemperate, 64, who, on examination, showed a tumor limited above by the upper border of the second rib, on the right by the sternum, on the left by the mammary line, and which was continuous below with the heart. The diagnosis was aneurism of the ascending aorta, and galvano-puncture was practiced. Two needles were inserted in the third interspace to a depth of one inch and a fifth, and one inch and a half apart. Fifteen Daniell cells were used (seventeen volts). The first sitting lasted sixteen minutes. The patient was better the same afternoon; the pulse fell from 118 to 90, was stronger, and the tremor was smaller; the respiration

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was freer and less frequent. Twenty cells were used for fourteen minutes twenty days afterwards, and four applications made the cure complete.

Hydrarthrosis of the knee has been repeatedly relieved by galvanism, and a case is reported by Dr. Castaneo, of Buenos Ayres (*Revue Medicale*), in which a cure was promptly effected after blisters, cautery, and other radical measures failed. Many instances are now on record evidencing the rapid absorption of pleuritic effusions under galvanism, and others of abdominal character (not encysted); hence the success might logically be looked for in any joint effusion where the integrity of the articulation had not been destroyed.

Silva-Aranjo and Moncorvo communicated their first note on the treatment of elephantiasis by electricity to the Academy of Sciences of Paris in 1880, and to the Academy of Medicine in 1881. More than a century ago Henley treated a case successfully (*Alard, De l' Inflammation des Vaisseaux Absorbans* (*sic*) *Lymphatiques, Dermoides et Souscutanes*, Paris, 1824, p. 589). When Silva-Aranjo first applied electricity to elephantiasis of the scrotum, in 1879, he neither knew of this case nor of those of Beard and Rockwell (Tibbit's "Hand-Book of Medical and Surgical Electricity," London, 1877). The authors employ forty to sixty Trouve elements, the negative to different affected points, and the positive on the sound skin near by. They sometimes use Faradic currents in conjunction, but their reasons for doing so are not apparent. The duration of each application is from fifteen to thirty minutes, and in severe cases electro-puncture with needles is resorted to.

Trials have also been successful in the service of Professor Oliveira Ferjao, of Lisbon, and are in progress at Vienna, in the division of Professor Kaposi, by Riehl. Their conclusion is that, if not infallible, electricity is certainly the best agent in our hands at present for the treatment of this formidable disease. We have no account of the treatment by electricity in this country aside from those already noted, but the frequency of the disease would certainly afford wider experiment than has heretofore been reported.

Faradism.—The induced current has been used in pleural effusions of varied kind and degree, as reported by a number of Continental authors, and their results agree with our own, so far as hastened absorption of serum was concerned in later stages of acute pleurisy.

In obtaining condensation of the uterus where involution has

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not progressed satisfactorily after labor, the Faradic current is highly recommended by several reporters. Some ten years ago we gave the detailed history of a number of cases of subinvolution treated entirely by electricity and we are glad now to notice, at last, one of our critics as having been converted after his plainly-expressed disbelief. We have had excellent results always in such cases, and also in hypertrophy of the organ from many other causes, notably from submucous fibroids. Recently a lady who declined surgical measures has parted with her fibroids (two in number) under careful Faradization, and this without taking ergot or any other drug.

The ordinary Faradic coil as usually wound with a single secondary of a uniform gauge of very fine wire will not answer for treatment of deep-seated visceral organs. An arrangement of multiplex coils of varying specific resistance wire and different area, in cross-section of both wire and spool is necessary, as described in another place.* The number of binding-posts in ordinary Faradic batteries is no criterion of their value, the secondary being merely looped out at points and connected to these posts. Intensity in such cases is just as well governed by the draw tube, and accidents from short circuiting in poorly-covered wire are liable in this plan of construction.

Obstinate hiccough is reported as cured by Faradism, but the current has failed in our hands, although faithfully tried, in a hospital case, which gave way at last to monobromide of camphor, cannabis Indica, and sumbul.

In psoriasis, acne and prurigo, Faradic currents have been reported, within the past three months as successful in many cases, some of them inveterate in their severity.

Static Electricity.—In the *Progres Medical* we find, incident to the phenomena of static electricity, the case of a young woman suffering from ovarian hyperæsthesia and hysteria, who possesses increased bodily electricity. Brushing her hair produces crepitation and sparks, light substances cling to her finger-ends, and dry clothing wraps her limbs so tightly as to impede voluntary movements. The intensity of the phenomenon coincides with her feelings: when highly charged she is well and sprightly; when not, she is dull and depressed. Damp weather disagrees with her as it does with the static machine, and after repeated discharges she feels exhausted. These phenomena

*"The Causes and Treatment of Constipation," Philadelphia Medical Times, July 23, 1888, and Proceedings of the Philadelphia County Medical Society, vol. v. p. 173.

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cannot be averted by the wearing of silk under clothing, as might be expected, but the application of the "electric wind" is at once efficacious in restoring her spirits, no matter how much depressed she may at that time be. Our plan of applying the "wind" or "bath" is to insulate the patient, connect the stool with the *outside* of one jar by chain, and then through a ball rheophore connected with the *outside* of the other condenser, make a thorough "general" application. The jars must be disconnected, and the "brush" made as long as possible, to obtain the peculiar refreshing effect.

Vigoroux contributes to the same journal an article on the prevention of cholera by the use of static electricity. He refers to the experiments of Boillot, Angus Smith, and Chapuis, which prove the great disinfecting power of ozone, as produced by the static machine, and the stimulus to nutrition by the electric bath (insulation on platform). He believes that daily baths are the best prophylactics against cholera; but the unreliability of machines, as generally made, militates against their use extensively, even if the theory were correct,—which we doubt.

The Toepler-Holtz of James W. Queen & Co., of this city, is the only static-electric machine in our experience which is *uniformly* reliable in all weathers, but it requires care to keep it so in humid summer months if not incased in an air-tight cover. Properly covered and kept *free from dust*, it will work satisfactorily at any time.—*Wm. R. D. Blackwood, M.D. in Medical Times.*

Typho-Malarial Fever.—This name, originally used by the late Dr. J. J. Woodward to designate a group of cases observed during the late war among the soldiers of the Army of the Potomac, in which the symptoms of typhoid fever were believed to be modified by a malarial complication, has come to be regarded as indicating a hybrid disease—a cross between typhoid and malarial fever—with symptoms and lesions of a composite nature. Prof. Bartholow, as far back as 1867, maintained that the "new" disease possessed no specific characters, and that the morbid anatomy of typhoid fever acquired no peculiar features from a malarial complication. He reviews the question in the Medical News for September, and points out that typhoid is the fever of old, cultivated, and densely populated countries,—malarial of new and sparsely settled localities; and that, as populations increase, typhoid supplants malarial fevers, and during the transition a mixed fever may prevail. Typhoid fever in a person infected with

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malarial poison is not only modified in its symptoms and course, but malarial poison ceases to be active in the presence of active typhoid poison. Although it is several years since Dr. Woodward formally retracted the opinion he had previously maintained, and admitted that there is nothing in the morbid anatomy of these cases to distinguish them from ordinary cases of typhoid fever, the influence of his earlier writings still dominates the medical opinion of the day. Prof. Bartholow undertakes to show the real relation of the two elements composing the mixed fever:—Typhoid fever is characterized by remissions and it is, therefore, a remittent fever. In some cases there is constipation and absence of gurgling in the right iliac fossa; and in some of malarial remittent there is diarrhœa and gurgling, Remittent fever commonly assumes a continued type, and it is somtimes attended with the "typhoid state." The resemblance is all the greater since in many cases of typhoid sweating is a pronounced symptom. Prof. Bartholow is of the opinion that when typhoid poison is acting in the body, any existing malarial poison becomes quiescent, remains so during the predominance of the typhoid action, and manifests activity again at the close of the typhoid fever. It may thus, if unrecognized, greatly prolong convalesence. Typho-malarial fever is not a specific type of disease.

Bactero-mania.—In the Medical Section of the French Association for the Advancement of Science, M. Delore advocated the bacterian origin of eclampsia, on the following grounds:—

1. There is often nephritis and albuminuria;
2. There is post-mortem elevation of temperature;
3. There are circumstances pointing to the contagiousness of eclampsia;
4. In scarlatina and measles convulsions frequently occur;
5. Death often occurs in eclampsia.

We have reason to apprehend, from the extraordinary progress made by bacterioscopy and the facility with which the most momentous conclusions are deduced from grounds of conjecture and analogy, that the day is not very far off when some microscopist of particularly robust and vigorous imagination will disturb the whole subject of physiology, normal and abnormal, by successfully cultivating the *vis a tergo* and proving that it is a germ.

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Cholera Germs.—The *Medical Record* is authority for the statement that Dr. Van Ermengen has successfully cultivated and inoculated the comma-bacillus. He concludes from his experiments that the pathogenic action of the germ is due to an unstable albuminoid. The discovery of this germ in cases of cholera is not difficult; and the discovery of it in cases of a doubtful nature is of value, not only in diagnosis, but as affording opportunity for the early and efficient employment of prophylactic measures. The French Cholera Commission now have the floor. Klein, with contemptuous humor, refers to his bacillus banquet, and Bochefontaine is about to delight his alimentary canal with another meal of choleraic discharges.

Gonorrhœal Rheumatism.—Professor Vogt has obtained results that are satisfactory to himself, from the intra-articular injection of a solution of corrosive sublimate. In three cases of the disease, he injected, every fourth day, forty-five to seventy-five minims of a solution containing one grain of the mercurial and ten grains of salt, in an ounce of distilled water, into different parts of affected knee joints. We are left in ignorance concerning the duration of the treatment, but the admission that massage and passive motion were still employed at the time when the alleged successes were reported, would seem to indicate that the learned gentleman has been somewhat premature in ascribing important results to his well-intended measures.

Typhoid Fever.—Prof. Ebstein's recent paper, based upon 235 cases of the disease, may be regarded as reflecting the opinions of modern German therapeutists. He regards the early employment of calomel with favor; antipyretic medicines are to be used only when persistent high temperature is attended with serious nervous or circulatory symptoms; and baths may be used when other antipyretic measures have proved inefficient. He lays especial stress upon supporting measures. In short there is nothing peculiar in his views, or different from those of the majority of enlightened physicians.

Vaccination: The New Way.—We suspect that Bourgeois, who recommends the hypodermatic injection of vaccine lymph in preference to the ordinary method of vaccination, has not received the latest returns from Evanston. We have reason to think that an eminent practitioner of that delightful suburb, who has had more experience in the subcutaneous injection of vaccine lymph than he has found enjoyable or profitable, could give the distinguished French innovator some ideas about the causation of septic abcesses.

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Locomotor Ataxy: A New Symptom.—The *British Medical Journal* directs attention to the fact that ataxic patients experience difficulty in walking backward at a time when they may have no trouble in walking forward. Their heels catch the ground. They dare not move for fear of falling. If they succeed at all in walking backward it is in a halting, odd, and timorous fashion, which at once attracts attention.

Tendon Reflexes in Diabetes.—Professor Bouchard considers the absence of tendon reflexes in saccharine diabetes a prognostic indication of grave significance. In forty-seven cases of the disease in which there was persistence of the tendon reflex, there were only two deaths; and in nineteen cases with absence of the reflex there were six deaths.—*Canadian Practitioner.*

Diphtheria and Croup.—At the meeting of the Medical Society at Berlin, Nov. 12, Prof. Virchow said that the difference between croup and diphtheria was one of symptoms and not of membrane. Stripping off the membrane is bad practice.

Goitre.—The inutility of arsenical injections into the substance of the tumor has been demonstrated by Dr. Dumont, of Switzerland, in an experience of twenty-six cases.

Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

How and When in Therapeutics.—Two great points should always be borne in mind in the execution of any pursuit in life, i. e., the *how* and *when* to act. There are always some laws or rules, that, if adhered to, will bring more successes than failures. Whether these laws emanate from true scientific sources or from empirical observation, it matters not, provided they have stood the test of time.

In therapeutics, more than in anything else, the strict observance of rules is positively required, for a single agent may have different effects according to dose, time and form of administration, and conditions of the organism. We all know that the alkaloidal salts of cinchona are the best antipyretic agents; yet, how very often are they reported to fail? Sometimes the failure is attributed to a bad preparation, others to insufficiency of dose and, not infrequently, to an idiosyncrasy. The

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practitioner is seldom willing to shoulder the responsibility of its non-success, and consequently does not take pains to search its cause or causes.

The stomach is generally selected as the recipient for medicines; this viscus, in vacuity, is in a constant state of desquamation, which forms in its internal surface a gelatiniform coating, and this goes on increasing in the intervals between meals. A quinine pill placed on this surface, is not only inhibited from its contact with the absorbing organs, but it is in part deteriorated by the action of this epithelial mass which takes the role of a ferment. Again, in pyretic states, there is frequently a deficiency in the secretion of the peptic glands, which, by interfering with the digestion, gives rise to a saburral condition of the stomach, and any therapeutical agent, chiefly if instable in its composition, falling into such a stomach will be necessarily delayed, decomposed or eliminated, unacted upon.

In children, ladies, and people in general of a peculiar aversion for medicaments, a great difficulty is met with in the selection of the adaptable form in which the indication should be fulfilled. If quinine is the agent selected, when a saburral condition exists, the solution by means of an acid, the powdered crystals or a capsule containing this substance in a powdered form, should be preferred. This, however, should be preceded by an evacuant, with the object of removing, from the gastro-intestinal tract, a large portion of the fermentable substances there accumulated. If exquisite sensitiveness of the gustatory organs, irritability of the gastric viscus, or inability of its absorbents, should be present, the rectum should be selected as *via* of medication, the agent being used either in a clyster, containing no more than two ounces of fluid; or in a suppository, which is preferable in children. In both cases, the administration of a lavement must anticipate them. A small portion of opium should be added to the agent used by the rectum to favor its tolerance, but in children's practice this should be employed in minute doses, as they are very easily narcotized, cases being on record in which *one single drop of laudanum* has caused lethal effects, and also a fatal narcosis in a nursing infant, resulting from a medicinal dose taken by its mother. Fatty substances charged with quinine or other alkaloidal salts, have, in the hands of some practitioners, proved successful, applied with friction, to the external integument; but the utility of this method is questionable.

Lastly, we will consider the hypodermic system, which undoubtedly possesses great advantage over all others, if the patient is willing to

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submit to it. When quinine is the agent to be used hypodermically, it should be thoroughly dissolved and as free from acid as possible; for this the *hydrobromate of quinine*, which is soluble in about 16 parts of water; or the *hydrochlorate of quinine*, which is soluble in about 34 parts of the same liquid, are the best adapted. The addition of alcohol, in the proportion of 3 parts to 10 of water, is an excellent dissolvent for the alkaloids and resinoids, and does not increase the irritant properties of the solution.

There are many other alkaloidal substances which, by virtue of their instability, are almost wholly destroyed in the stomach, by the action of ferments, when the internal aspect of this viscus is such as to cause considerable delay in their contact with the absorbing organs. Aconitine, that is a very potent toxic alkaloid, even in minute doses, meeting in the stomach with active ferments, may become almost inert. The glycosides are yet more sensitive; the delay and exposure to a high temperature in the stomach decompose them into sugar and other substances. Digitaline is one of the most easily decomposed glycosides, and this explains its inactivity in a great many cases. The alkaloidal salts of opium are very tenacious in their composition, they may be detained in the stomach or placed in contact with active ferments but their action will be manifested, even if somewhat later and modified.

We have considered the gastric cavity when empty, now we shall study it when replete, as a recipient for medicaments. We can not demonstrate it better than by the following experiment of Cl. Bernard. By feeding rabbits, during three days, on grass, then during one day, on carrots, he found that these last recently ingested, formed a sort of cylinder, which occupied the central portion of the chymous pulp. It is obvious, that what happens with food, occurs with medicine, when placed on a full stomach, that is, during the process of digestion, it will occupy the centre of the chymous pulp, and thus deprived of its contact with the absorbing organs, may only be absorbed when the nutritive substances dissociate in the lesser intestines. This imports loss of time, decline of energy and, frequently, nullity of action. Among the agents which act differently on an empty or a full stomach, we have the *acids* and the *alkalies*. Acids, chiefly hydrochloric and phosphoric, when taken fasting, check the formation of acids in the stomach, due either to the action of the gastric glands or to abnormal fermentation of the starchy, saccharine and fatty elements of food. When administered during the process of digestion they increase

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the acids of the stomach. Alkalies, principally the alkaline carbonates, given in small doses (10–15 grs.), on empty stomach, promote the flow of the *acid gastric juices*; on full stomach, in larger doses (ʒii.ʒi), they neutralize them, though not in a permanent manner. It follows then, that the *mineral acids*, chiefly *hydrochloric* and *phosphoric*, are indicated whenever there is an excess of acid formation in the stomach, administered before meals, and the *alkaline carbonates*, in small doses, fasting, when there is deficiency in the amount of those acids. The *alkalinization* of the *gastric acids* by a large dose of an *alkaline carbonate*, being but a temporary action, is better accomplished by the acids on empty stomach.

Beef Tea—What is It?—Beef tea is an aqueous solution, by ebullition, of a certain portion of organic matter and some soluble and insoluble salts. Chevreul, in his analysis, gives, for a thousand parts of beef tea, 15 parts of soluble organic matter and from 15 to 20 parts of soluble and insoluble salts. The former represents the *osmozome*, or the extractive matter of beef, as it was formerly called. This extract contains some assimilable principles, as *fat*, *inosites*, *inosic acid*, and *sarcolactic acid*, but also abounds in non-assimilable principles, and consequently useless, as *gelatine*, *creatine*, and *creatinine*. Among the soluble salts in beef tea, we find *chloride of sodium*, *alkaline phosphates* and a small quantity of *chloride of potassium*; the insoluble salt is represented by the *phosphate of calcium*, which, by the aid of the *sarcolactic acid*, is kept in solution.

It follows from this analysis, that beef tea, which is deemed so useful to the feeble and convalescent, can but furnish little material to the organism, unless it should be absorbed in large quantities. In this manner it acts not only as an analeptic and restorative, but also as an aperient and stomachic.

Good beef tea should be acid, and it is owing to the acidity that it acts as a stomachic.

A very useful addition to beef tea, is from four to five drops of hydrochloric acid to the quart. The role of this acid is simple:—1st. It favors the solution of a certain quantity of albuminoids that would have been coagulated by the heat; 2nd. It dissolves the phosphate of calcium of the bones and thus furnishes a restorative to the system; 3rd. It adds its acidity to that of the gastric juice. Besides, beef tea is one of the preparations by means of which we introduce into the organism a great quantity of chloride of sodium; that is a

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very indispensable mineral principle. It is evident that beef tea is rather a stomachic than a nutritive agent. In view of the above, we comprehend that extract of beef, which cannot be compared with beef tea, is a useless preparation, if not altogether dangerous. Dogs fed exclusively with it, died either from inanition or because they had assimilated creatine or creatinine, which are but waste matter that the organism should eliminate, as urea, uric acid, etc.

Effects of Bromoform, Bromethyl and Bromophyllin.—Bonome and Mazza, from a series of physiological experiments recently conducted in the laboratory of Professor Alberton, of the university of Genoa, obtained the following results:

1. Bromoform is a general anæsthetic. Dogs and guinea-pigs almost always show the same symptoms of anæsthesia and muscular relaxation, following inhalation, that the human subject does. In five experiments upon men, three were well narcotized, lasting even for a whole hour; in two (probably on account of the use of a defective preparation containing free bromine) there was no narcosis, but on the contrary, irritation of the conjunctiva, a flow of tears, burning in the eye, etc. The narcotic action they believe to be a little slower in appearing than when chloroform or ether is used, but the success is apparently the same as with both these valuable anæsthetics.

2. The narcosis obtained from the inhalation of bromoform is free from the stage of exaltation which results from chloroform. On this account preference should be given bromoform if the patient is subject to epilepsy or alcoholism. Billroth and Nussbaum have each directed attention to the danger of exciting fits in epileptics by the use of chloroform.

3. Bromoform does not disturb the respiratory function, but after prolonged narcosis there is slight reduction of the blood-pressure. The respiratory fluctuations of the blood-pressure in the course of the narcosis are very regular; the pulse remans strong. In none of the dogs did bromoform cause sudden arrest of the heart's action, such as is often seen during the use of chloroform.

4. During the bromoform narcosis, while it was noticed in dogs that there was decided mydriasis, in man there occurred only trifling alterations of the pupil; there was neither nausea nor vomiting. The

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quantity of bromoform required to cause complete narcosis is less than that of chloroform as commonly used.

5. In the first few hours after narcosis, it was noticed that there was a sinking of the temperature exactly as after chloroform, but the patient recovered sooner from its effects.

6. Given by the mouth, bromoform acts as a hypnotic and anæsthetic.

7. Bromoform prevents putrefaction in organic substances as urine and meat. Bacteria are not developed in the presence of bromoform.

8. Injected under the skin, bromoform is fatal when given in a dose of two grains for every three ounces of bodily weight.

Ethyl bromide produces narcosis more quickly than chloroform or bromoform, but is more easily eliminated from the system, and on this account its effects are more temporary. It is to be recommended for short operations. It is less active than bromoform, and becomes poisonous at a point of each 2.25 gr. for 3 ounces of bodily weight. Whilst the narcosis reduces the blood-pressure at first, it rapidly increases again after the termination of the narcosis, when the respiration also is accelerated. Bromide of ethyl also reduces the irritability of the cerebral cortex, and hinders the development of bacteria in organic infusions.

Ethyl bromide does not produce complete narcosis upon inhalation, but, when pushed, causes death by abolishing cardiac activity.—*Phila. Med. Times.*

Scrofula and Infantile Syphilis.—The author endeavors to demonstrate, that scrofulous lesions are in the majority of cases, manifestations of tuberculous infection, and, moreover, that those affections called scrofulous by the old time practitioner, have a close relationship with a certain degree of syphilitic infection, chiefly hereditary. In the modern school there is no such thing as scrofula; this old diathesis ought to be eradicated from our nosological tables; part of the facts related to it must take a place among the tuberculous, and the rest among the syphilitic manifestations.

These are the author's conclusions:

1. There is no reason to admit a scrofulous diathesis. The lesions denominated simple cutaneous or mucous scrofulides are nothing but ordinary inflammatory processes. The majority of the malignant scrofulides are local tuberculosis. 2. They are dependent upon an

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infectious origin, as the syphilitic lesions. There is, however, this difference between the virus of the tuberculosis and that of syphilis, i. e., the former may exist without the human organism, and be indirectly transmitted by the atmosphere, while the latter requires a direct inoculation. 3. The two virulent principles, on favorable grounds, have the tendency, first, to produce local lesions, and afterwards to become general and give rise to systemic affections of more or less gravity. 4. The contamination of the blood by the tuberculous infection may sometimes provoke pyretic reactions of great intensity, as in the case of acute general miliary tuberculosis. 5. Other times, the tuberculous infection developes slowly, in an insiduous manner, causing specific lesions of the skin, subcutaneous and cellular tissues, articulations and bone. These are precisely the lesions classed by the old books as scrofulous. 6. They offer, by their aspect, pathological anatomy, evolution and multiple terminations, more analogy with tertiary syphilis. 7. When syphilis and scrofula co-exist in the same subject, the two affections follow, as a rule, each its particular evolution without influencing one another in the least.—*Dr. Gamberini: Translated from Jour. de Med. de Paris.*

Quinine in Scarlet Fever.—During my experience of 40 years, I have always observed that the scarlet fever ferment, is manifested by characteristic pyretic paroxysms each one appearing later than the preceding, and coinciding with an exanthematous eruption. If sulphate of quinine is administered from the beginning, the intervals between the paroxysms are almost apyretic, and though they may be intensified, the last being usually the most pronounced, they never become fatal. The quinine hinders their pernicious action, in the malignant form of the affection.

The paroxysms number three or four, more frequently three. The first appears about 1 p. m.; the second between three and four, and the third about nine. The last paroxysm is preceeded by an almost complete apyrexia, it is the most violent, and terminates towards morning with an exanthematous eruption. This attained its maximum rubor and gradually fades to an orange red hue.

The progress of scarlet fever is regulated by the use of quinine, and its pernicious effects are conjured.

If quinine is indispensable in the acute period of the malignant fever, it is yet more indispensable against the secondary symptoms. At present these secondary symptoms are considered as the result of

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the action of cold upon the skin which has become more sensitive after its disquamation. It is, however, overlooked that a general eruption of the skin has an action upon the kidneys and predisposes to nephrites. This nephritic disturbance is ushered in by the presence in the blood of the ferment or microbia of the scarlet fever, rather than by the action of cold. Frequently the œdema of the face appears irrespectively of the most strict caution not to take cold and before desquamation has occurred.

The continuation of the quinine treatment will prevent the nephritic phenomena. If not used in the primitive symptoms because of their mild character, quinine is an indispensable medicament against the sequella.

In closing, I beg of my confreres to bear in mind these assertions, for they are the issue of my experience.—*Dr. W. S. Diberder.*

Treatment of Dysentery by Ipecacuanha.—Although the good effects of the powder of ipecacuanha root, in large doses, in dysentery, are a recognized fact, yet this mode of treatment is not so diffused as it deserves, for there is an impression among practitioners, that it only succeeds in the dysentery of hot climates and also because they fear to provoke vomit, which would increase the sources of waste already existing.

Dr. Jocelyn Seaton, who, in his capacity of attending physician to the emigrants, averages 20 cases of dysentery, to treat a day, considers ipecac the best medicament against dysentery; which he administers as follows:

1st. Abstinence from *liquids for two hours.*

2nd. Introduction in the rectum of an opium suppository.

3rd. Application, 20 minutes after of a poultice of linseed meal and mustard over the epigastrium.

4th. Ten minutes after the administration of 40 gr. of the powder of ipecac root, in a biscuit or in wafer, which is followed by a tablespoonful of milk or ricewater, to aid its deglutition.

5th. The patient is recommended to keep the recumbent position for two hours, at least, abstaining from any drink.

Administered in this manner, this medicament has been in the author's hands, in hundreds of cases, as efficient as quinine in malarial fevers.—*Therapeutic Gazette*, August, 1884

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Insusceptibility to Vaccination.—The *British Medical Journal* for November contains an editorial on this subject which embodies the following statistics furnished by the Local Government Board:

Year.	Successful.	Insusceptible.	Year.	Successful.	Insusceptible.
1872	698,000	1693	1877	766,000	926
1873	702,000	942	1878	761,000	840
1874	727,000	920	1879	757,000	742
1875	722,000	838	1880	750,000	859
1876	763,000	848			

Because persons are registered as "insusceptible," it does not follow that such insusceptibility is a permanent condition of body with them, or that they are safe from small pox. Legal insusceptibility, namely the possession of a medical certificate that a child has been unsuccessfully vaccinated three times, and is, in the certifier's opinion, insusceptible to successful vaccination, is different from real and absolute insusceptibility as a permanent condition of body.

Treatment of Seborrhœa Sicca (Dandruff.)—

R.	Sulphur. Præcip.	16 gram.	(240 gr.)
	Bals. Peru	2 gram.	(30 gr.)
	Ol. Theobromæ	12 gram.	(180 gr.)
	Ol. Ricini	48 gram.	(720 gr.)
M.	Fiat pomatum.		

The proportion of castor oil and cocoa butter may be altered according to the season of the year to obtain a pomatum of adaptable consistency. This is applied on the scalp once a day, after washing it well and sponging it with a solution of bichloride of mercury, in the proportion of 1–5000 of water, drying it before applying the pomatum. —*El Repertorio Medico*, Oct. 1884.

Treatment of Chorea by Bromide of Nickel.—The "Rivista Internazionale di Medicina e Chirurgia" reports a case of chorea in a woman 45 years of age, which resisted the treatment by *paraldehyde, chloral, brom. pot., electricity* (constant ascendant), and yielded in a fortnight to the use of *brom. of nickel*, in the dose of 1.20 gram. (20 gr.) four times a day.—*Dr. Vidal. El Repertorio Medico*, Oct. 1884.

A radically disposed aspirant for obstetrico-chirurgical fame, was once asked what he would do in a case of post-mortem hemorrhage. He promptly replied, "dilate the os and search for bleeding vessels." The Royal College of Surgeons should take notice.

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Laryngology.

Edited by GEO. F. HAWLEY, M.D., 125 State St.

Cold Snare versus Galvano-Cautery.—The advantages claimed for the cold snare over the galvano-cautery, in the various operations about the nose and post-nasal spaces, have both been accepted and denied ever since its introduction by Jarvis of New York

That it has been discarded by many, we think is due to the neglect of following out the directions given by him, Seiler and others, in not allowing a sufficient time for the operation. This is particularly true in the operation for removing posterior hypertrophied tissue of the inferior turbinated bone.

The hemorrhage following is due, not to any fault of the instrument, but to an improper haste on the part of the operator.

It is as necessary here as in all surgical operations not to limit ourselves as to time. In all the cases in which we have employed this instrument, we have not met with a single instance in which this trouble has appeared, the patient on leaving merely being warned not to forcibly blow the nose for twenty-four hours.

Another important feature which would lead us to prefer the cold snare is the dread which patients, particularly those of a nervous temperament, have of the galvano-cautery. The best of us dread any operation which we think is associated with pain, and it is far more difficult to convince one that the pain of a hot wire is not more severe than that of a cold. This may appear but of slight importance, but he who is or has been in active practice will see the justice of this remark. The surgeon who operates in the simplest manner possible and with the least show, will give the most satisfaction to himself and his patients.

We are not, however, yielding merely to the fancy of our patients in preferring Jarvis's snare to the cautery. The reaction of the cautery is frequently severe and prolonged, while that of the cold snare is comparatively nil. This is partially due to the fact that while we can regulate the action of the cold snare we cannot always that of the cautery. Frequently a greater amount of tissue is destroyed than is necessary and the reaction may be very severe. In one case which came under my observation, the patient was confined to his bed for nearly two weeks.

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Jarvis's snare can be employed upon the most delicate of patients with but little, if any, after inconvenience and with but little after treatment.

It is only in the removal of growths where one wishes to destroy the stump or pedicle, fearing a recurrence, that the superiority of the cautery loops may be perhaps sustained. Still, even here, this supposed advantage is in our opinion rather in theory than in fact, for statistics go to show that recurrent tumors return as often when operated upon by the galvano-cautery loop as by the cold snare.

It is only by the complete removal or ablation that we are sure of a non-recurrence. If this is not accomplished the simple burning of the stump by the cautery will tend by irritation to provoke a recurrence rather than to retard or prevent. The same law applies in recurrent or malignant tumors about the nose or post-nasal spaces, as in other parts of the body, that a complete and thorough destruction of the growth is needed to prevent any return. This the cautery loop does not do with any more certainty than the snare, while it possesses the disadvantages already mentioned.

The needles which Jarvis has introduced increases the value of his snare as well as its field of usefulness. By them we can operate upon sessile tumors or out-growths as readily as with the galvano-cautery or knife, and without fear of injury to the neighboring parts. It is when limited spaces are to be acted upon, as enlarged follicles or veins, that the galvano-cautery gives the best satisfaction—though, even here, the various acids or London paste will do quite as well.

The following cases may show some of the advantages claimed by the cold snare:—

Case I. A child twelve years of age came to the Chicago Throat and Chest Hospital suffering with post-nasal catarrh. Upon inquiry we found that she had been treated for adenoid vegetations by the galvano-cautery. The inflammation caused by the instrument extended to the middle ear, causing an acute suppurative otitis.

After considerable trouble and coaxing a second operation was performed by the cold snare after Bosworth's method, and several large growths were removed. She was requested to return in three days but did not for over a week, when the mother stated that the child was much better and had apparently suffered but little from the operation.

Case II. Was the removal of a thickened or enchondrosed deflected septum. The hypertrophied tissue was first transfixed by

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two needles, the snare being placed over them and about the part to be removed, was gradually tightened until it had cut its way through the thickened tissue. The tumor was thus removed with the needles attached. Upon examination of the other nostril we found a cicatricial union between the inferior turbinated bone and the septum midway between the outer and posterior openings, the result of an operation performed by the galvano-cautery for posterior hypertrophy. This was removed by the knife and the parts separated by iodized wool until they healed. Like the first case the patient suffered from no after unpleasant effect, contrary to his experience when operated upon by the hot wire. Several other cases might be cited to show the advantages of the Jarvis's snare ecraseur over that of the galvano-cautery if space would permit, but we think these two which are selected from many will suffice. In conclusion we will quote from Bosworth in an article entitled Growths in the Nasal Passages, and published in the *Medical Record*, Jan. 13, 1883:—

"As regards the absolute destruction of these growths, or, in fact, any morbid growths of any size by the galvano-cautery, I have only this to say. It is an immensely over-estimated instrument and, in my experience, has utterly failed to accomplish what we formerly anticipated from it.

"If we apply a cold electrode to a tumor and then close the circuit the loss of heat is so great that as a rule a more than dull heat is not obtained; the result is but a very superficial charring of the mass. In the vault of the pharynx this procedure only is applicable as a rule, for it would require very nice manipulation to pass a heated electrode to the point desired without touching healthy portions of the passages. Still if this was done, and an electrode was in, while the heat was developed before entering, there is yet but a very superficial destruction accomplished, and the ablation of even a small tumor by this means becomes a tedious process occupying weeks and months, requiring an interval between each application for the exfoliation of the slough, and this may be attended by the unpleasant accompaniment of an offensive discharge."

Mullein in Phthisis and Asthma.—Mullein has recently been used quite extensively in the St. Vincent Hospital, Dublin, Ireland, in the treatment of phthisis and certain forms of asthma. So popular did it become that patients, far and near, flocked to the hospital for treatment. It was given in the following manner. One ounce of the dried

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leaf was added to one pint of milk, which was placed over a fire till it reached the boiling point. As soon as it boiled the milk was taken from the fire and strained through a coarse cloth. This was taken during the day, one-half in the morning and the rest at night. In cases of diarrhœa it seemed to check the discharges. The leaf is to be smoked and inhaled in case of asthma, in the form of a cigarette. A little tobacco can be added if unpleasant to the taste.

Dermatology.

Edited by HENRY J. REYNOLDS, M.D., 2200 Michigan Ave.

The American Dermatological Association.—The American Dermatological Association held their eighth annual meeting at Highland Falls, near West Point, New York, on the 27th, 28th and 29th of August last, with Dr. R. W. Taylor, of New York, in the chair.

Papers were read by Dr. Hardaway, of St. Louis, on "Case of Xanthoma Multiplex of the Skin;" and also on "A case of General Idiopathic Atrophy of the Skin;" Dr. J. Nevins Hyde, of Chicago, on "A Clinical Study of Lupus Erythematosus of the Hand;" Dr. Sherwell, of Brooklyn, on "A Suggestion Respecting the Treatment of Acne and Acne Rosacea in the Male Subject;" Dr. White, of Boston, on "A Case of Unilatteral Chromidrosis," also one on "Cases of Arsenical Dermatitis;" Dr. Duhring, of Philadelphia, on "Dermatitis Herpetiformis and its Relations to Impetigo Herpetiformis of Hebra;" Dr. Stelwagon on "A Case of Late Cutaneous Syphilis;" and also one on "A Case of Vitiligo involving the whole Surface;" Dr. Robinson on "Miliaria and Sudamina;" and Dr. R. W. Taylor on "A Peculiar Ringed Affection of the Glands and Prepuce."

After a generally interesting and instructive meeting the Association adjourned to meet on the last Wednesday in August, 1885, at the Indian Harbor Hotel, Greenwich, Conn.

Treatment of Acne.—In a recent lecture in the College of Physicians and Surgeons of Chicago, by Henry J. Reynolds, M.D., Professor of Dermatology, in speaking of the treatment of acne, considerable stress was laid upon the management of those forms wherein the lesions have a tendeney to become deep in the tissues, even, as they are in many cases, entirely subcutaneous and manifested by an apparently papular or tubercular lesion, without in many instances, much if any

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inflammatory redness of the skin of the involved part, and described by various authors as *acne indurata*, *acne cachecticorum*, etc. In those forms he said the true lesion will be found to be *papulo-pustular*, the nodular induration containing, deep under the skin, pus; assuming in reality the character of a dermic or subcutaneous abscess. This condition, he said, is generally encountered in anæmic, cachectic or strumous subjects. The lesions were originally superficial, but from retained pus, sebaceous matter, etc., a thickening of the epidermis over them, and a cachectic tendency of the tissues to break down beneath, they gradually burrowed deeper as pus formation took place. This condition may not necessarily exist as a separate form of the disease, but may occur intermingled with other lesions in any case of acne of long standing. These lesions can never be cured by topical applications, internal remedies nor by the two combined. They must be treated upon surgical principles. They must be cut, and deep enough, if it be a quarter of an inch, to open into the pus sack, which may be quite small. Will they get well then? Not necessarily, although this is the only operative treatment usually laid down in the books. They will immediately heal over on the surface, leaving the miniature *pyogenic nidus* behind to continue its work as before. There is only one sure way, and it is sure in every instance, and that is to destroy the diseased tissues and have the lesions heal from the bottom. He said "I am in the habit of lancing deeply, being sure to strike the centre of the nodular enlargement, with a Graefe's cataract knife, squeezing out the contents, touching the bottom with a probe dipped into strong carbolic acid, then inserting a piece of absorbent cotton just large enough to fill the incision from bottom to top, and covering the whole with plaster. This he removes in thirty-six hours. That is about all that is necessary; if they seem inclined to close at the top too soon they can very readily be kept open by the gentle use of the probe, the hot water bathing of the parts and other processes laid down in the books being kept up in the meantime as thought advisable." The same treatment he thinks also works well with the more superficial and common pustular lesions of acne in many cases, by destroying at once the sebaceous glandules and follicular structures which might otherwise ultimately develop into lesions similar to the above. Occurring in connection with the *hyperæmic maculæ* of *acne rosacea*, as these lesions sometimes do, the treatment has the advantage of generally destroying the macular condition. No visible scars of any consequence are caused by the process.

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Dermatitis Herpetiformis.—Among the papers read at the last meeting of the American Medical Association was one under the above caption, by the well-known author Dr. Duhring, of Philadelphia. Under the name *Dermatitis Herpetiformis* the author groups as different forms of one and the same disease that have been considered by other authors as separate and distinct skin diseases, or diagnosed as peculiar manifestations of certain common skin diseases, as herpes, eczema, pemphigus, etc., and in some instances as unknown diseases; exhibiting in their various manifestations either erythematous, vesicular, papular, bullous or pustular lesions; all quite rare, however, and among them the disease described by the celebrated German author, the late Von Hebra as "*impetigo herpetiformis*," which he embraces under the pustular form of *dermatitis herpetiformis*, and also the disease described by some authors as "*herpes gestationis*," which he seems disposed to class in the vesicular variety of the disease he describes.

He summarizes by saying that he has endeavored to show:

1st, "The existence of a distinct, well-defined, rare, serious, inflammatory disease of the skin, manifestly of an herpetic nature, characterized by systematic disturbance, a great variety of primary lesions, by severe itching and burning, and by a disposition to appear in repeated successive outbreaks.

2. "That the disease is capable of exibiting itself in many forms, all having a tendency to run into or to suceed one another irregularly in the natural course of the process.

3. "The principal varieties are the erythematous, papular, vesicular, bullous and pustular, which may occur singly or in various combinations.

4. "That it is a remarkably protean disease.

5. "That the pustular variety is the same manifestation as the disease described by Hebra under the name '*impetigo herpetiformis*,' this being the only form hitherto described.

6. "That the several other and equally important forms are worthy of special remark.

7. "That the term '*dermatitis herpetiformis*' is sufficiently comprehensive and appropriate to include all varieties of the process.

8. "That it may occur in both sexes, and in women independent of pregnancy.

9. "That it usually pursues a chronic, variable course, often lasting for years, and is exceedingly rebellious to treatment.

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From Dr. Duhring's able investigation, description and classification of the conditions above referred to, the general conclusion arrived at by those making a special study of skin disease seems to be that the author is right in classifying them all as varied manifestations of one and the same disease; some diversity of opinion remaining, however, as to the propriety of the name proposed. It would seem, as the lesions of the disease as described, assume various other elementary types besides those characteristic of herpes (vesicles), that "*dermatitis multiforme*" might be a more appropriate name; however, one would presume that a man might legitimately assume the right to name his own disease.

Surgery.

Edited by G. FRANK LYDSTON, M.D., 125 State St.

Acute Septic Glossitis, followed by Œdema Glottidis.—Acute inflammation of the tongue is not a very common affection, and perfectly typical cases are relatively rare. In the cases recorded, the inflammation has apparently limited itself to the tongue and in such cases, with appropriate treatment, recovery has been the rule. I have recently met with a case, however, in which the inflammatory process, limited at first to the tongue, extended to and involved the contiguous tissues so rapidly that it is quite different from any of the reported cases so far as I am aware, and consequently merits publication.

Wm. B., 37 years of age, and a real estate agent by occupation, presented himself to me upon the 5th of May, complaining of a "sore tongue." He stated that for several days he had noticed a small ulcer upon the posterior portion of the left side of the tongue. This had given him no special trouble until a few hours prior to his visit to me, when the tongue began to swell, and became very painful, there being also severe pains in the left ear. In the history of the case, I elicited the fact of a probable specific eruption some nine or ten years ago. He had always been a very hard drinker, but within a few weeks had lessened his indulgence in alcoholics to a great extent.

On examining the tongue, I found the left side of that organ considerably swollen, the swelling being limited by the median raphe. The ulcer, the history of which I obtained, could not be seen on account of the swelling. On inquiring as to the possibility of some local irritant having come in contact with the ulcer and thus excited the in-

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flammation, I found that for some days the gentleman had been practicing with a small rifle and had been in the habit of carrying the cartridges in his mouth. The day before the inflammation began, he had exposed himself to the weather and had wet his feet, and he thought, had taken cold. When I first examined the case, it exhibited marked constitutional disturbance, prostration being especially pronounced, and there being evidently several degrees of fever. I administered a saline cathartic and ordered the patient to bed, with constant application of ice to the tongue. This was at noon of May 5th, and my next visit was made about 6 p. m. of the same day, when I found that the inflammation had extended to the right side of the tongue, the entire organ being so swollen that the patient could barely speak. The glands of the neck had already begun to swell and had become very painful. The bowels not having moved I repeated the saline. I also ordered a mixture containing the muriated tr. of iron and chlorate of potassium, the application of ice to be continued. At 10 p. m. I was sent for, the patient having grown steadily worse since my previous visit. A consultation was now called. The tongue and fauces had become so swollen that swallowing had become impossible and the patient could no longer speak. The glands of the neck, and the surrounding cellular tissue had become so swollen that the neck was nearly double its natural size. The temperature was 105° Far. in the axilla. The fauces could not be seen, the tongue filling the mouth completely. To my mind the proper procedure at this stage would have been free incisions into the tongue, but "wiser counsel prevailed" and the operation was deferred. Ice was continued, with the application of hot poultices to the neck. As attempts to swallow only served to annoy the patient, medication by the mouth was stopped, but a hypodermic dose of ¼ gr. of pilocarpine and ¼ gr. of morphia was administered. The morphia was added on account of the severe pain in the ear of which mention has been made. In the course of half an hour, profuse sweating was induced, with the result of lowering the temperature, but such a large amount of mucous accumulated in the fauces and bronchi from the action of the pilocarpine that the respiration became very much embarassed. During the night I applied two leeches to the tongue, with the immediate effect of reducing the swelling considerably, so that in a short time the patient could speak tolerably plain and could swallow fluids. Stimulants and nutriment, with ammonia and digitalis, were now given at frequent intervals. The tongue continued to diminish in size and by the evening of the 6th the

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fauces could be quite plainly seen, and were found to be greatly swollen and infiltrated. During the night of the 6th swallowing again became very difficult, and by the morning of the 7th considerable obstruction to respiration was evident. The voice, which had been impaired by the swelling of the tongue and fauces, but which had become tolerably distinct, was now reduced to a husky whisper, and by noon the characteristic respiration of œdema of the glottis was fairly marked. There being no immediate danger from asphyxia and not being able to make a satisfactory examination of the glottis with the finger, I did not suggest an operation until about 6 p. m., when the swelling of the fauces had so far diminished that I could feel the œdematous glottis quite plainly. Symptoms of exhaustion were at this time very marked—although an abundance of stimulants and nutriment had been taken and retained during the day—and the pulse was too rapid and feeble to be counted. The urine upon examination was found to contain about 10 per cent. of albumen. Altogether there was little hope of success following an operation, but as respiration was markedly obstructed it was decided to perform laryngotomy. I therefore operated about 6:30 p. m., with the assistance of Drs. Landis and Paoli. Respiration although remaining quite rapid, became free after the operation, the pulse temporarily improved, and the patient finally slept quite comfortably for several hours. At about midnight, however, the pulse became suddenly imperceptible, and 1 a. m. the patient quietly expired.

This case is interesting both on account of the infrequency of acute glossitis and its peculiar malignant character. In none of the reported cases to which I have access, has there been such rapid extension of the inflammation to contiguous tissues and such a pronounced involvement by the lymphatics of the neck, which in this instance was as marked as in certain malignant cases of diphtheria. The occurrence of œdema of the glottis was precisely what might have been expected in any severe inflammation of the mouth and fauces, particularly in a patient with renal complication from alcholism. As for the cause of the inflammation, it evidently must have been a very powerful local irritant. Whether the copper cartridges had poisoned the ulcer upon the tongue is questionable, and I think it more probable that a small portion of food lodged in the ulcerated surface, and decomposing, caused a local septic poisoning. Certainly the rapidity of invasion, and extension of the inflammation, the speedy and pronounced involvement of the glands of the neck, and the severe constitutional symp-

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toms would bear out such an assumption. Such local sepsis has been known to occur, and with a fatal result. General septic poisoning has resulted in a similar manner, and Richardson* relates a case in which a gentleman was fatally poisoned by a small particle of potted hare which had become lodged in a small ulcer in the roof of the mouth. In the case under consideration, I was struck by its close resemblance to a case of my own which I saw in 1880 at the N. Y. Charity Hospital. In this case a small ulcer at the angle of the jaw became infected with some unknown poison and suddenly inflamed, with marked constitutional manifestations. The inflammation extended very rapidly, involving the glands of the neck, the fauces, and within twelve hours, the glottis. The swelling was so great that cerebral symptoms resulted, apparently from obstruction to the venous circulation. A laryngotomy was performed, but without success, the patient dying six hours after the operation.

It is well known that excessive drinking, with irregularities in diet, is liable to cause inflammation and ulceration of the tongue of a chronic character, and such habits would of course afford a strong predisposing cause for acute inflammation, hence in such a case as the one under consideration, a comparatively slight irritation of any ulcerated surface which might be present upon the tongue, would suffice to excite an acute glossitis.

According to Fairlie Clark, acute glossitis may be due to "taking cold," the contact of septic substances, or of a tainted atmosphere, and the contact of acrid and corrosive substances. Mr. S. Cooper states that it may arise spontaneously or else from some special irritant such as mercury or other poisonous substance.

Regarding the nature of acute glossitis, but little has been said. For my own part, I am under the impression that the inflammation is, in the majority of cases, an erysipelas of the tongue, the special characters of which differ from those of erysipelas in other tissues simply on account of a difference in the structure of the part involved, principally as regards its density and the absence of cellular tissue. As for the treatment, I believe that it should be managed upon the same general principles as other forms of erysipelas, viz., local depletion and systematic support. That free incisions would have saved this case is questionable on account of the complicating nephritis, but such measures have proven very successful in similar cases. Such have been reported by Erichsen, and by Wyeth. The earlier perform-

*Diseases of Modern Life.

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ance of laryngotomy would have prolonged life, but I hardly think it would have affected the ultimate result. I must say, however, that I am in favor of early operation, but we cannot always act according to our best judgment, and it is often difficult to secure consent to an operation until the urgency of the case is plainly manifest to even non-professional observers. There is something very suggestive in the close resemblance between the secondary changes attending such cases of glossitis as the one cited by Richardson, and myself, and such diseases as facial carbuncle, malignant pustule upon the face, malignant diphtheria, and cellular erysipelas of the face and fauces. There seems to be a local septic intoxication with constitutional prostration common to all. The therapeutical indications are surely identical throughout.

Treatment of Erysipelas.—In a recent number of the Nashville *Journal of Medicine and Surgery*, Dr. Humphreys presents the claims of iodized collodion in the treatment of erysipelas. Extraordinary success is claimed to have been obtained during five (5) years use of the application, which is said to be due to the protective and refrigerating properties of the collodion, in conjunction, probably, with the antiseptic properties of the iodides in the solution. The following formula for the iodized (?) collodion is given as obtained from Walzl's *Photographic Rays of Light*, Jan. 1878:—

℞ Aether Sulph.
Alcoholis aa ʒx
Pyroxylonis ʒii
M. Salve et adde

℞ Ammonii iodidi ʒii ℈ii
Cadmii iodidi ℈ii
Cadmi Bromidi ℈ii
M. Sig. Apply with camel's hair brush. P. R. U.

The constitutional treatment is not neglected by the author.

It would be difficult to appreciate the advantages of the iodized(?) collodion over the ordinary form which others have recommended in erysipelas. It would seem disadvantageous to mix the iodides with the collodion, if dependence is to be placed upon its contractile and refrigerating properties, as they must certainly be impaired by such admixture. We very much doubt the antiseptic powers of solutions of the iodides, except they be used internally, or in such a manner as to liberate free iodine. The solution might as well be termed bromized collodion, as it contains that ingredient, and bromine is a far more powerful antiseptic than iodine. That the salts of bromine, however, are antiseptic, we greatly doubt. For our own part, we have not been

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led to entertain great faith in either the antiseptic or refrigerant treatment of erysipelas. Exactly how the advocates of such a line of treatment would achieve anything but the most deplorable results in the phlegmonous variety of the disease, we cannot understand. The rational therapeucis of erysipelas may be formulated as follows: 1st. Constitutional support by iron, (we prefer the salicylate to the chloride), quinine and dietetic measures, alcoholics being in a large number of cases a sine qua non. The old-fashioned treatment with calomel and opium, the former in very moderate doses and the latter in amount sufficient to allay pain, is very efficacious in sthenic cases, and particularly in the cutaneous variety. 2nd. Locally, the indications are, first, to exclude the air and light; second, to allay pain third, to relieve tension and counteract the tendency to the formation of pus and sloughs.

In the simple cutaneous variety of erysipelas we meet with some few cases in which cold applications are very grateful, but in by far the majority of cases, hot applications are better. The reason for this is obvious, viz.: Erysipelas is of all inflammatory diseases the most asthenic, speaking in a general way, and there being a depression of tissue vitality, any measures which would tend to enhance this depreciation should be scrupulously avoided. In facial erysipelas or in the cutaneous variety in any situation, applications of sheet lint saturated with hot lotio plumbi et opii, and covered with oiled silk should be made. In the phlegmonous and cellular forms, oakum poultices of tow, saturated with the hot lotion or even hot water, should be applied and the whole covered with oiled silk. These applications should be changed frequently. They fulfill indications 1st and 2nd. Indication 3rd should be met by multiple incisions in the affected part through the skin and cellular tissue. These should be from one to three inches in length. Bleeding is to be encouraged by warm fomentations, and is never severe. Finally, the oakum poultice should be applied. We can say from a large experience in the management of the worst forms of erysipelas, as seen in public institutions, that we have never known a patient to die from uncomplicated phlegmonous erysipelas when this line of treatment was thoroughly carried out. In fact suppuration and sloughing were rare. By contrast with cases treated in a less radical manner, such results were remarkable. When such a line of treatment is not followed, there is nothing more tedious than the management of phlegmonous erysipelas. Troublesome sinuses, prolonged suppuration, extensive ulcers and cicatrices, and often

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death from exhaustion or septicæmia, are among the results obtained by passive expectancy.

Injury of the Urethra.—In the November number of the *Peoria Medical Monthly* appears an account of a case of injury to the urethra, reported by Dr. Anderson, of Nebraska. The case is a very interesting one, but its successful termination under the treatment followed is rather surprising. Fortunately, however, children are more tolerant of such injuries than the adult. In this case, the patient, a lad of ten years, fell astride a wagon wheel. Retention of urine followed and continued 24 hours, when Dr. A. was called in consultation. The child was then suffering from severe vesical tenesmus and pain, and complained that the urine was entering the scrotum. The scrotum, perineum and right groin were extensively bruised and swollen. Efforts to pass a catheter were unsuccessful. Expectant treatment was deemed advisable, but the bladder becoming greatly distended, aspiration was resorted to. This was repeated (it being meantime impossible to pass a catheter) at intervals until the fourth day, when the scrotum and thigh presented evidences of infiltration. An incision was then made into the scrotum with resultant escape of the urine, which continued to flow from the artificial channel. An abscess subsequently formed in the right iliac region from which a large quantity of pus was evacuated. The fistula was subsequently operated upon and the urethra found to have been completely severed (as might have been expected). Cure was complete, the natural channel being restored.

It is astonishing that such expectancy should have resulted favorably. Had it been an adult, death from extravasation, with resultant pyæmia or exhaustion would have been inevitable. The treatment in every case of rupture of the urethra with retention, should be immediate permeal section, with free incisions into any points of extravasation. This is the only safe measure and it is our belief that passive expectancy is responsible for most of the deaths which result from rupture of the urethra.

A New Hermaphrodite.—According to the *Medical Record*, a true case of hermaphroditism has been discovered in the person of an individual styled most appropriately Madame Duplex de Balzac. The general physique is said by Lusk to be feminine, the sexual organs masculine, the case being one of hypospadias. Prof. Polk, on the other hand, pronounces the case a genuine hermaphrodite.

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Eye and Ear.

Edited by J. E. HARPER, M.D., 163 State St.

Cocaine in Eye and Ear Diseases.—The new local anæsthetic, muriate of cocaine, is engaging more attention from medical men than has any therapeutic agent since the discovery of anæsthesia from the inhalation of ether. Although only a few months have elapsed since attention was first directed to it, the experience of all who have tested its merits tends but to confirm the claims of its most enthusiastic admirers. The marvelous effects of cocaine in lessening and destroying the sensibility of mucous surfaces and subjacent tissues, admitting of extensive surgical operations being performed without pain, has been fully demonstrated. Wonderful as it is, the sphere of this drug is not limited to its action as a local anæsthetic for surgical purposes. Its field of usefulness has not yet been clearly defined, but it has already been used with marked success in many painful affections for which no satisfactory remedy heretofore existed.

In diseases of the eye and ear although our experience has been limited, we find cocaine an invaluable aid, especially in the treatment of those of an acute and painful character.

Aside from allaying pain and relieving spasm and photophobia, cocaine acts upon the vaso-motor nerves in a way to lessen the calibre of the minute vessels, thus diminishing congestion and hastening a return to a normal condition of the diseased structures. It frequently will dilate the pupil more quickly and powerfully than any other mydriatic. Combined with atropia it acts better in diseases of the iris and cornea than either when used alone. It undoubtedly serves as a valuable adjunct in all acute and painful affections of the conjunctiva and anterior portion of the eyeball, especially of the cornea and iris. In glaucoma it appears to exercise a beneficial influence by allaying pain and relieving the increased intra-ocular tension.

Cocaine supplies a great desideratum in the treatment of acute diseases of the external auditory canal and the middle ear. The common earache, so frequent in childhood, can be safely and quickly relieved by a few drops of a four-per cent. solution.

To review the diseases of the eye and ear in which cocaine can be employed with advantage would be but to rehearse the list of acute and painful disorders which affect these organs.

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We feel confident that future experience will demonstrate that the few failures reported are due to a want of accurate knowledge of how it should be used, and not to a want of efficiency on the part of the drug.

Society of Ophthalmology and Otology.—At a meeting of the Chicago Society of Ophthalmology and Otology, Dec. 8, 1884, Dr. Boerne Bett man read a paper on the use of peroxide of hydrogen in the treatment of chronic suppurative otitis media.

Dr. B. recommends the use, about twice a week, of a solution containing 12 volumes. After cleansing the ear with absorbent cotton a few drops of the solution are thrown in by means of a dropper, or, in case the perforation in the membrane be very small, by the aid of a hypodermic or eye syringe. The free oxygen immediately attacks the pus, destroying the corpuscles and bacteria,and thoroughly emptying the cavity of the tympanum of all septic matter. The action of the peroxide is attended with considerable ebullition, but very rarely does the patient complain of pain. In a few minutes the ear can be packed with boracic acid as in the dry method of treatment. Dr. B. claims to have cured in a few weeks, by the above plan, cases of long standing that had been treated with boracic acid and other remedies for months unsuccessfully.

Dr. E. L. Holmes asked what action the peroxide would have upon aural polypi. Dr. B. answered that he was not prepared to say definitely but did not think that it would be of much service in their treatment. This led to a discussion of the best means of destroying polypi. Dr. Holmes had been very successful in the use of alcohol as recommended by Politzer. Dr. J. E. Colburn also testified to the good effect of alcohol. Dr. E. J. Gardner relied upon chromic acid in all cases too small for the snare, and to touch the pedicle after the removal of a large polypus. Dr. Lyman Ware mentioned a case in which the polypus filled the external meatus, and as the patient objected to instrumental interference he ordered powdered alum blown into the ear once daily. This treatment removed all traces of the growth in a few days. Dr. J. E. Harper had been equally successful in the use of powdered alum for the destruction of polypoid growths in the ear and nose. He had also seen alum cause large venereal warts to disappear in a few days, even after they had resisted nitric and chromic acid.

Treatment of Granular Eyelids.—A long memoir on this subject, which is the *bete noire* of ophthalmologists, has lately been contributed to the *Recueil d' Ophthalmologie* of M. Galezowski by Dr. Vouckchevitch,

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and this observer strongly recommends the excision of a flap from the conjunctival fold on the following grounds: that no specific remedy has yet been discovered for granular lids, that is to say, for true trachoma; that caustics, astringents and antiseptics are quite ineffectual in removing the granulation; that inoculation with blennorrhagic pus can only be employed in a few properly-selected cases, especially those in which pannus is present; that jequirity (the seed of the *abrus precatorius*), has not as yet been sufficiently studied to enable any positive statement of its value to be made; and even if the two last-mentioned remedies are sometimes successful, it seems that they cure the complications of granular lids rather than the granulations themselves; that the abrasion of the granulations recommended by some authors, as by M. Heissrath, is not unlikely to cause troublesome malformations of the lids; that most ophthalmic surgeons admit that the granulations are more numerous in the *culs de sac* than in other regions; that in consequence of their position, and of the anatomical relation of the eyelids to the globe, they are very difficult to attack by ordinary caustics; that excision of the *cul de sac* heals old granulations; and lastly, that their excision leaves no troublesome deformity of the eyelid, and is an operation that can be performed with ease. There cannot be a doubt, however, that much care should be exercised in regard to the size of the flap that is removed. It should not be too large, and the operation should not be undertaken till the usual and more simple methods of treatment have been fairly tried.—*Practitioner.*

Obstetrics and Gynecology.

Edited by E. P. MURDOCK, M.D., 130 S. Halsted St.

An Unusual Case of Labor.—The patient was a thin, weather-beaten looking woman, 41 years old, first confinement, native of Ireland and had always been accustomed to hard work. Of her previous history we could learn but little as the patient was quite ignorant and extremely averse to "talking to the doctor." Saw her Sept. 23, at which time she thought she was about two weeks over time, and with a view of preparing herself she had taken two and one-half ounces of castor oil "to open the bowels." When I arrived she had been purging several hours and was suffering the most intense pain. On examination

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I found no effort at dilatation of the os and no indication that the labor proper had begun. Thinking the pain and general prostration was due to the cathartic I suggested hypodermic medication for immediate relief, but this excited the fear and prejudice of the patient, hence I prescribed viburnum and deodorized tincture of opium. Saw her again the next day and found her quite comfortable. September 26, was called again and found that the liquor amnii had already escaped but the labor was not progressing.

The patient refused all anodynes saying she was already over time and would not take morphia, chloroform, or anything else in fact. So with a courage akin to desperation she struggled on through her labor resisting all offers of assistance as if fighting against some agent of witchery. After six hours she was delivered without any seeming accident, but the pains continued after the delivery of the placenta as if the labor had not been completed. I then gave opium and viburnum and left her resting. Was called next day and found her suffering the same excruciating pain as before, and a large swelling on the left iliac region. I then made an examination on pretence of removing some clots and found a small rent in the body of the uterus about two inches above the external os. A soft rubber catheter introduced into this passed entirely into the abdominal cavity though, the rent was not more than one inch long.

I called Dr. O. J. Price in consultation and he confirmed the diagnosis of rupture of the uterus. The temperature had then risen to 105° (F.) and the pain could only be controlled by large doses of opium. Thirty-six hours later she died—no post-mortem. The case to me had some points of interest on account of the age of the patient, she having been 39 years old when she was married, the extreme violence of the labor, the purgative two days before throwing the entire system into such violent excitement, and the natural progress of the labor in its later stages. Hence we submit it without comment.

Pessaries.—Dr. William Turver, of Parkdale, Canada, has devised a new anteversion pessary which he calls a modification of Gehrung's pessary, and from letters supplementing his report we would infer that he has found something even more beneficial to suffering humanity than St. Jacob's Oil. Let us hope for the best, for anything in this line is welcomed by the despairing gynecologist as dernier ressort, as one by one the anteversion pessaries have been thrown into the waste-basket.

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Pediatrics.

Edited by MARCUS P. HATFIELD, M. D., 3446 Wabash Ave.

Diabetes Mellitus a Sequence of Pertussus—Recovery.—The particular lesion lying at the foundation of diabetes millitus is a matter of some doubt. But the fact that it seldom occurs in young children (infants) and that it is usually fatal makes the following case one of some interest. It also throws light upon the experiment of Claude Bernard, et al., in puncturing the floor of the fourth cerebral ventricle.

Anna M——, age 11 months; a vigorous, active and rather precocious child, was attacked with whooping cough in the usual manner. The early stage of the disease was treated by rather heroic measures as recommended by Meigs and Pepper, depending largely on full doses of belladonna for six consecutive days, but as the cough gradually grew worse, and presented every appearance of becoming one of unusual severity, Dr. C. W. Earle was consulted, and upon his recommendation a medicated spray to the throat was used, depending largely upon sulph. of quinia, carbolic acid, etc., but with little or no relief. Then, internal medication was almost entirely abandoned except a little bromide of ammonia to secure some rest and sleep, and the house was thoroughly filled with the vapors of cresoline. This gave more relief than any other measure, the spasms of coughing became less frequent and less severe. But the child continued to emaciate until she became a mere skeleton and as helpless as an infant of six weeks The eighth week of the attack the paroxysms had almost subsided and the cresoline was withdrawn. Within twenty-four hours the coughing returned, and in two of these paroxysms the mother almost despaired of the child ever recovering its breath.. Asphyxia seemed complete; the face became a dark purple, the eyes bloodshot, the tongue protruded, the extremities and body became pale and cold, but finally the spasm relaxed as if the end had come, and then the child gasped, and under strong stimulus of rubbing and artificial respiration it breathed again. A few hours later it was noticed that she passed enormous quantities of urine, at the same time she would persist in holding the head backward with all the symptoms of spinal meningitis, except that the temperature did not rise above 101° (F.). The amount of water drank by the child was alarming, and the amount passed correspondingly large. I saw the diapers

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changed eighteen times in seven hours; in every instance I could wring water out of the cloth.

I introduced a small catheter and then drew off five ounces of urine within twenty minutes after the child had urinated freely. Upon the application of Haines' copper test I found the urine contained a large proportion of sugar; of course this alarmed me. I immediately gave five minims of fluid extract of ergot, and hurried to consult Drs. Henry M. Lyman and C. W. Earle. They both advised the vigorous use of ergot and potass. bromide. These remedies were pushed to their utmost and the sugar slowly disappeared, and in ten days it seemed to have entirely disappeared, but on the fourteenth day returned. Slowly subsided only to return less severely at periods from seven to fourteen days for nearly three months with final recovery. Ergot and bromide were depended upon entirely, and when the symptoms returned they were quickly relieved by this medication. Even now there are occasional returns of the profuse urination or polyuria, but I have not been able to detect sugar for several months. These disturbances seem to be always produced by, or rather accompanied with marked nervous disturbances. I might here add that I have a report of a case (" unofficial ") from Peoria, Ill., almost identical except that the child died. My case seems now—nine months after the original attack—to have entirely recovered. I am aware that this case above proves nothing, but feel called upon to report it, as I know of nothing of the kind in medical literature. The rationale of my treatment was based entirely upon the physiological experiments of Claude Bernard, and I submit the facts for what they may be worth.—*E. P. M.*

Editorial.

Reciprocal Courtesy.—The editorial pages of the Columbus *Medical Journal* for December, 1884, are occupied by a luminous, and otherwise extraordinary discussion, of the "Bill for Establishing a Board of Medical Examiners, in Ohio," which was prepared and adopted by the Ohio State Medical Society, and is to be presented to the legislature, for action, during the present session.

The aim of the bill is to improve the quality and tone, and hence the respectability of the medical profession of the commonwealth; but, as we, of Illinois, have only a general, and neighborly interest in the final

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disposition of the proposed measure, we need not concern ourselves with its merits or demerits further than to say that, as a whole, in its objects, and the means suggested for their accomplishment, it is deserving of, and should receive, the unanimous, hearty, and unfaltering support of every medical practitioner in the state.

Our object in the present article is to caution our estimable contemporary of the Columbus *Medical Journal*, that his vehement and absorbing desire for the success of the bill, may, at some future time, make him so intolerant of even the shadow of indifference in others, that he may find himself, when engaged in answering critics and annihilating opponents whose standing is superior to his own, exhibiting the methods and the manners of a ward politician. We have said critics *and* opponents, because we remember that a severe critic may be a sincere friend.

Indeed, even at the present time, there is ample ground for a suspicion that our estimable contemporary has been beguiled into making a very economical expenditure of truth, and a very lavish expenditure of slanderous insinuations, under circumstances where sagacious silence, or convincing argument, would have been in better accord with his deserved reputation for practical wisdom and high moral sense.

We agree with him unhesitatingly, unreservedly, and enthusiastically, that prompt and vigorous action, in improving the tone and respectability of the profession of his state, is imperatively demanded. If the optimistic reader is disposed to take issue with us, and claim that the profession of Ohio is, in all respects, equal to that of other states, we invite him to contemplate the editorial in question, remembering that the editor is superior to the common herd and is devoting his exalted energies to the laborious task of elevating his brethren of the backwoods to the plane of refined and dignified accomplishment which he occupies himself.

The warrant for the foregoing pleasantries is to be found in the fact that the bill alluded to, by reason of its novel and interesting features, has not only been extensively criticised, but, as might have been expected, it has met with the opposition of such "physio-medical" and "vito-pathic" mountebanks as luxuriate in Ohio, and there, as everywhere, resist any attempt to protect a community by giving a clean and definite form to the medical profession which presides over its destinies.

A copy of the document was transmitted, by one of its admirers, to the editor of the journal of the American Medical Association, with a

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request that he would discuss its various terms in the editorial pages of the periodical to which he has given shape and character, and with which his name will always be honorably connected.

It will be admitted by all, even by the journalistic autocrats of the "metropolis," that the Ohio gentleman selected for the business of friendly and competent criticism, is one of the most earnest and persistent advocates, and consistent exponents of reform in medical education, which the profession of this country has produced.

The venerable editor who is well known to be as humorous as a meat axe, humorously acted as if he had been asked for his opinion in good faith, and actually discussed the instrument with some vigor, and, without implying lack of sympathy with its general aim, pointed out the dangerous possibilities it embodied.

The critic referred plainly to methods, and not to objects; but, notwithstanding this, the unexpected seriousness of the criticism has been construed by the journalistic elevators of the profession in Ohio, as proof of hostility to any attempt at improving their neighbors.

Although the editor, now really serious, took pains in the succeeding issue of the journal, to repudiate the construction that had been put upon his words, some of the Ohio periodicals are yet ablaze with indignation.

If such indignation had any reasonable or substantial foundation, or had been expressed in terms of courtesy and truth, it would, doubtless, be echoed in every medical paper in the land.

Such, however, is not the case. The Ohio journalists, who are struggling for elevation, expect opposition from the medical colleges of Chicago, because it is well known "That these colleges have all along antagonized the Illinois State board of Health, and their motive in doing so is evident."

This is not as well known as it ought be, if it is a fact. We, of Chicago, have been thinking that our colleges, of every kind, have, from the beginning, earnestly co-operated with the State Board. They have had representations in this organization, and they have them now.

Their requirements are above those of the State Board, and, excepting the one relating to preliminary education, they were above them at the time the State Board came into existence. The college with which the editor of the journal is connected, required evidence of a good English education for several years before the State Board was appointed.

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There is probably not one college in Chicago, and certainly not a regular institution, that does not know of some of its undergraduates and rejected candidates for graduation, running the gauntlet of the State Board, almost every year. Why our colleges should find it necessary, or to their interest to oppose the Illinois State Board, or any similar organization in a neighboring state, more than the medical colleges of Ohio do, it is not easy to comprehend from a comparison of their requirements. The average duration of the course of instruction in the regular colleges of this state, four in number, is 24¼ weeks, and the average percentage of graduates to students is 28¼. In the irregular colleges, three in number, the average length of the session is 22 weeks, and the average percentage of graduates to students is 35⅔. In the regular colleges of Ohio, eight in number, the average duration of the term is 22¼ weeks, and the average percentage of graduates to students is 36½. In the irregular colleges, four in number, the average length of session is 22¼ weeks, and the average percentage of graduates to students is 35¼. Hence, so far as these figures, taken from the "Proceedings of the Illinois State Board of Health," throw any light on the question they tend to show that Ohio contains several colleges; and that the regular institutions are lower in rank than the irregular ones, and lower also, than both the regular and irregular institutions of Illinois.

The Ohio journalists, who are conscious of the need of elevation, refer to the "motives" that inspired the editor of the *Journal* in preparing the criticism which he had been requested to publish, in such terms as convey the implication that he is fully alive to the necessity of preserving some spot on the domain of this broad republic, as a sort of reservation, where the graduates of the college with which he is connected may be allowed to deal out death and destruction without any fear of molestation from any officious Board of Examiners who might insist on inquiring into their qualifications. They also charge that he is using the *Journal* as the mouth-piece of his college, and is prostituting his editorial position by subordinating the desires and interests of the profession at large to the necessities of that institution. They further charge that his opposition(?) to their particular bill occupies precisely the same ground as that taken by representatives of the "World's Dispensary," and "Warner's Safe Liver and Kidney Cure."

We know but little of the professional status of these institutions of learning, and we are not sure that they desire to elevate it; but we feel safe in hazarding the opinion that in length of session, and in per-

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centage of graduates to students, they might occupy a place of honorable prominence in Ohio.

The medical colleges of Chicago would rejoice if the state authorities gave the "requirements screw" another turn or two, for then the alumni of these colleges would have a practical monopoly of the right to practice medicine in the State of Illinois.

Righteous indignation at real or fancied wrong is one thing, and defamation of character is another.

There are very few men who would question the integrity of the honored editor of the *Journal*, or his sincerity in working to increase the usefulness, not only of medical men, but of all mankind. There is one, however. He lives in Columbus.

If there is a man in all this land who has earned the respect and admiration of his professional brethren for his attitude on all questions of professional improvement and interest, it is N. S. Davis.

If there is one who has tried harder, or with more consistency of example for well-nigh half a century, to raise the standard of scholarship and of moral character among physicians; or one who has exhibited greater promptitude and uniformity of action in subordinating social claims, pecuniary interests and personal comfort, to the promotion of this single object, we should be glad to learn his name.

In relation to the college of which Dr. Davis is the honored Dean, we may say that we know something of its policy—of its outward show and its inner life; and we know, as the world knows, that there are precious few of its more pretentious rivals which can bear comparison with it, or with any of the regular colleges of Illinois. Lest it be imagined that we have "interests" in that college, or other interests as ignoble as those ascribed to the venerable Dean, it may not be amiss to say that we occupy a position of rivalry to him.

We are not defending the gentleman nor his college.

We would be ashamed of such a beggarly show of sensibility and appreciation as would give the impression that we considered defense necessary. We are simply saying that the "tone" of the Ohio profession is to be elevated. W. E. Q.

We are delighted to learn that the Prince of Wales has consented to become Patron of the Infirmary of Newcastle-on-Tyne, and that his Royal Highness has forwarded a check for fifty guineas as a donation. Haw! Mr. Prince, graciously permit us to introduce to your honor's Royal Highness, the Superintendent of the West Side Dispensary.

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Books.

A MANUAL OF DISSECTION OF THE HUMAN BODY.—By Luther Holden, late President of the Royal College of Surgeons of England, etc.; fifth edition. Edited by John Langton, Surgeon to and Lecturer on Anatomy at St. Bartholomew's Hospital, etc.; with over 200 illustrations. Published by P. Blakiston, Son & Co., 1012 Walnut street, Philadelphia, 1885. W. T. Keener, 96 Washington street, Chicago.

This book has become so well and favorably known through former editions, that we would have scarcely considered it necessary to more than mention the appearance of the fifth edition, had it not been for the extremely attractive style in which it has been issued. It would appear that the publishers had been stimulated by the thoroughness and masterly arrangement of the subject matter, and had endeavored to present it in a manner worthy of its contents. The classic works of Gray, Quain and Wilson, will continue to be the student's companions in his private study, but we would unhesitatingly say that Holden will take first rank as a guide to his dissections. By the aid of diagrams and plainly-worded text many of the most knotty problems which puzzle the tyro in anatomy are made so clear that "he who runs may read." The illustrations are very finely executed, and the whole make-up of the book reflects great credit on the publishers.

"THE ANNALS OF SURGERY."—Edited by L. W. Pilcher, M.D., and C. B. Keetley, F.R.S.

We take pleasure in announcing the appearance of a new journal devoted exclusively to the science of surgery. Such a periodical as the *Annals of Surgery* promises to be, will fill a void in American medical literature. If there is any department of our profession that feels the need of a journal devoted exclusively to its interests, it is that of surgery. Obstetrics and Gynecology are nobly represented by the *American Journal of Obstetrics*. Ophthalmology and Nervous Diseases have each an organ which is a model in its way, and it is surely time that the American surgeon was similarly favored. That the *Annals of Surgery* will not be found wanting when weighed in the balance with other journals devoted to special subjects, goes without the saying. The eminence of the editors is all that is necessary to recommend it.

THE PHYSICIAN'S VISITING LIST, for 1885, published by P. Blakiston, Son & Co., of Philadelphia, has arrived at its thirty-fourth year of publication.

This is *per se* a sufficient proof of its merit, if it is true that demand for any article increases proportionally with its value.

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Medicine.

Edited by WM. E. QUINE, M.D., 3151 Wabash Ave.

Pathology of Purpura.—In a contribution to the study of this subject (*Annales de Derm et de Syph.*, January, 1885), M. Leloir says that vascular lesions have been described in a few of the recorded cases, but in most of them no such lesions have been found. It is probable that many cases arise from alteration of the blood leading to intravascular coagulations, and capillary embolisms. The quantity of fibrin in the blood of purpuric patients, frequently exceeds that of health.

The author groups the pathogenic causes thus:

A. *Purpura from Modifications of the Vessels.*

1. From disturbance of capillary circulation, leading to active or passive hyperæmia, and hence, to diapedesis or vascular rupture.
2. Purpura télangiectasique of cornil.
3. From primary alteration of vascular walls, and consecutive rupture.

B. *Purpura from Modifications of the Blood.*

1. Too great fluidity of the blood (?).
2. Vascular obstructions (thrombosis, embolism), arising from clots, in blood dyscrasiæ, from white corpuscles, from bacteria, and possibly from altered blood elements.

C. *Purpura Nervosa.*

It is probable that alterations of the blood modifies the action of the vaso-motor nervous apparatus, and that this, or even primary disturbance of innervation, sometimes leads to cutaneous hemorrhage.

In many cases, however, the pathogenesis is complex, and does not conform to this classification. The author leaves the subject as he found it,—involved in obscurity.

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Purpura Hæmorrhagica from Emotional Cause.—The *London Medical Record*, August, 1884, relates the case of a boy, aged sixteen, of good family and personal history, who, the day following a severe fright, was obliged to leave work on account of epistaxis, malaise, and pain in the limbs and joints. The next morning he was covered with red spots, but felt somewhat better, and again went to work. Epistaxis again occurred, and was followed by copious hemorrhages from the anus, urethra, conjunctivæ, ears and nose. On the fifth day of the attack he was admitted to the General Hospital in a state of profound prostration. He was covered with purpuric patches, varying in size from a lentil to a shilling. Hemorrhage from mucous surfaces still continued, and the urine and stools were full of blood. Under a simple diet, with sulphuric acid, ergot, and perchloride of iron, the patient promptly recovered.

Purpura from the Use of Iodide of Potassium.—Two cases of extensive cutaneous hemorrhage have recently occurred in the practice of the writer, under circumstances that admit of no doubt as to their mode of origin. One patient was under treatment for syphilis, and the other for rheumatoid arthritis. In both cases the iodide, associated with other medicines, was prescribed in the dose of five grains, four times daily. In both cases an extensive purpuric rash, consisting of spots smaller in circumference than a pea, made its appearance within forty-eight hours. Both patients became alarmed and stopped taking medicine; but a few days later, experiencing no ill effects, and finding that the rash was fading, they resumed the use of the medicine. Again, in both cases, a fresh crop of blotches appeared, and the patients returned to the physican for explanation and further treatment. In both cases explanation was evaded, and the tincture of iron prescribed. One patient returned for the treatment of his original disease in about ten days, and the other in about three weeks. The former still presented a large number of faded spots. The physician, not connecting the appearance of the rash with the use of medicine, again prescribed the iodide, but now in simple solution; and again, an extensive rash appeared. The cutaneous hemorrhage was not attended by an appreciable disturbance, local or general. Several attempts have been made to bring the syphilitic patient under the influence of the medicine, during the past six months, but invariably with the result described. The rheumatoid patient, very properly, took alarm, and put himself under the care of another physician.

Tricuspid Stenosis.—In the *Revue de Medicine*, July, 1884, M. Chauffard alludes to the evidences of this condition that are discoverable during life, viz., venous congestion without venous pulse in the neck, and a presystolic murmur which culminates over the point of junction of the xiphoid cartilage with the sternum. He expresses agreement with authori-

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tative writers in the conclusion that the disease nearly always occurs in adult females, and is accompanied by other indocardial lesions, especially by mitral stenosis. It is the result of a slow endocarditis, wide-spread and not vegetative, which glues the bases of the valves together and makes them contract; and it is associated with rheumatism in only half the cases.—*Practitioner*, December, 1884.

Gastric Ulcer.—M. Debove (*Progres Medical*, July 12), describes a novel method of treatment of this intractable disease. He is governed by two principles: the avoidance of dilation of the stomach by ingesta, and the maintenance of functional rest. He washes out the stomach very carefully, and prevents gastric digestion by the free admixture of alkalies with the food taken. Three meals per diem are allowed, each consisting of powdered meat 25 grammes, and sodium bicarbonate 10 grammes. Washings showed that the contents of the stomach never became acid, and that no peptone was formed in the stomach of the patients treated. No alkaline cachexia followed, but the alkali seemed to exert a beneficial influence on the ulcer. The work of digestion is entrusted to the liver, pancreas, and intestine. Two cases, found intractable by other modes of treatment, resulted in recovery under this method.—*Practitioner*, December, 1884.

Variola and Varicella.—Dr. Bareggi (*Centralbat. für Klin. Med.*,) says that the cocci found in the papules and pustules of variola, are not present in the eruption of varicella.—*Medical Record*, December 27.

Pneumonia.—Dr. Lumbrosa concludes from culture experiments with material derived from four cases of infective catarrhal pneumonia, that the micrococcus, although identical in form with that of croupous pneumonia, does not possess identical properties. He was unable to reproduce the disease with pure cultures.

Rose Spots.—Dr. Rénoy describes in the *Archiv. Gen. de Med.*, October, 1884, (quoted by the *Medical Record*) two cases in which typical rose spots were present without typhoid fever, and concludes that the eruption is not an infallible sign of the disease. This discovery attracts less attention than it might do, if a punctate roseola, indistinguishable from that which occurs in typhoid fever, were not familiarly known to occur under widely dissimilar circumstances. The rash is not pathognomonic.

The Kleptococcus.—We learn with pleasure that Prof. Meandra, of Outopos, has succeeded in isolating the bacillus of kleptomania. It has long been thought that this disease owed its origin to an organism of a snaky, elusive nature, which rendered detection difficult, but it remained for Prof. Meandra to first demonstrate its existence. The difficulty was, of course, to obtain pure cultivations, contamination with the *b. panourgia*

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being very frequent and troublesome. At length Prof. Meandra secured a magpie of well-known thievish propensities, and removing a small portion of its brain under the spray, he began the first of his long series of experiments. The organism can be readily grown in beet-juice (prepared by beating beets and straining) or in cabbage-infusion. It stains easily, of a deep steel color. Under a power of 80 diameters this organism presents a hook-shape, thus ?, which gives it the name of Meandra's Interrogative Micrococcus; we would, however, suggest (with due deference to the Professors' taste) the name of hookeycoccus, both as more euphonious, and as applicable, no matter what position the organism may assume; it also indicates its character as well as shape. Injected subcutaneously into cats the effects of the hookeycoccus were remarkable. Several of these animals, let loose in a back-yard, were seen two days after to creep sureptitiously into some of the neighboring houses and kleptomize pieces of meat, fish, etc. While we cannot quote the whole of this important article, we relate one interesting event. A quantity of beet-juice, in which a cultivation was far advanced, was spilled on the floor of the laboratory. Three days after, the Professor missed his pocket book, watch, and other articles of value; it was also noticed that several houses in the place had been visited and valuables taken. Mr. Lestees, the Professor's assistant, a man of the highest respectability, was also missing. Professor Meandra thinks he must have inhaled some of the dried dust from the spilled cultivation. There was much excitement when the affair leaked out, and, as there are two banks in the town, the people petitioned the mayor to prevent all communication between the Professor and the cashiers. There is no doubt that an attenuated cultivation can be obtained, in which case the criminals confined in the prison at Moros will be vaccinated. We agree with this great investigator when he says: "The bacillus opens a wide field for thought—an almost unfathomable vista." * * * "Many generations must pass," he continues, "before the last microbe is stained and mounted, drawn and photographed, and stamped with the name of its discoverer." "The next 200 years will be known in history as the MICROBIAN AGE."—*N. Y. Med. Abst.*

Hæmorrhoids. — Dr. T. W. Poole, of Lindsay, Canada, expresses his opinion of this disease in the following language:—The piles! Aha! I know them well, Each feature, though I may not see 'em; Old foes, which fume, and fret, and swell, And vex and plague my perineum. You blush at mention of a "pile," And would perhaps the theme avoid; Well, then, suppose, to put on style, We call the thing a hæmorrhoid. Though bearing an ill-omened name, It seemed as if they might not pain us, When first, as visitors, they came, And took up lodgings in the anus. But

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now, at each succeeding bout, The pelvic pains appear distincter, And there can be no longer doubt of their relations with the sphincter. You ask me, by what obvious sign One may with certainty detect 'em. Well, I can only say that mine Are like a hornet in the rectum; Which, having wandered from the way, And angry at the situation, Stings right and left while yet it may, And tortures one in defacation. "Avaunt! it is a vulgar rhyme." Yet stay, there must be means to cure 'em: Oh, yes! if you but give them time, And meantime patiently endure 'em. There are a thousand cures, you know, All certain sure, as dead shot candy; 'Tis well to buy a score or so, And lay them by to have them handy. And when the hornet's rage is spent, And things assume their wonted quiet, The cure,—though it may not prevent, Will quickly quell the painful riot.—*Canadian Practitioner.*

Stammering.—A correspondent of the *London Lancet* writes (Sept. 27th) that stammering may be cured by making an audible note in aspiration before each word. Stammerers can sing as easily as other persons.

Dyspepsia and Indigestion.—These terms are usually regarded as synonymous, and are defined by Dunglison as equivalent. The French dictionary, by Littré and Robin, and the recent "Dictionaire usuel" gives to each term a distinct definition. In the "Real Encyclopadie" the term dyspepsia is considered as including indigestion. The name dyspepsia signifies difficulty of digestion. Now, digestion may be difficult, and attended by more or less suffering and disturbance of the nervous system, and yet be duly and completely performed. Dyspepsia may exist without indigestion, though they are often associated and the latter can hardly exist without the former. The point which I wish to make is, that the term dyspepsia denotes an affection distinct from, and irrespective of, indigestion, the latter term being considered as denoting an affection characterized by nausea, vomiting, flatulence, acidity, diarrhœa, etc.—symptoms which show the digestive functions to be either perverted or incomplete. —*Prof. Austin Flint, in N. Y. Med. Journal.*

A New Method of Counting a Rapid Pulse.—(By A. E. Hoadley, M.D., Prof. Anatomy, College of Physicians and Surgeons, Chicago.) In making use of this title, I admit it is quite probable that the method may have been made use of before, or possibly described, but as I have never seen it described or heard of its use, I claim it as original and deem it worthy of record.

My mind was set at work in this direction by reading an article some months ago on the same subject. I do not remember the author, nor can I find the article, as I have forgotten the journal in which it appeared. The method I refer to consisted in tallying the pulse with a pencil for a fraction of a minute and then counting the tallies. After making several

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trials of the above method, I came to the conclusion, that if counting a rapid pulse was of any practical or scientific value, there should be some easier and more convenient method of doing it, for this is not only unhandy but in many cases impracticable. The following method suggested itself:—As far as I can see there is not a single objection to it. By it one can count a pulse twice as fast as by the usual method, and do it easily and accurately. It consists simply in counting every other beat for a minute, and then multiplying by two. In counting every other beat one counts half as fast as the pulse beatings, which, with the fastest pulse is deliberate. But the physician who tries this plan for the first time on a rapid pulse, will in all probability fail, but with a little practice on a slower pulse will very soon acquire precision and certainty in counting a rapid one. My plan is to liken the pulse to the tick of a watch and imagine a to and fro beat and as soon as my mind is thus fixed, which is almost instantaneous, I proceed to count the to or the fro beat, as the case may be with perfect ease and certainty.

By placing a watch to the ear one can demonstrate how easy it is to count every other stroke of the lever, while it is nearly impossible to count them all.

Inunctions of Oil in Fever.—Colrat reports a series of observations on children. In a number of cases of scarlatina, small-pox, and bronchopneumonia, he has found the temperature lowered as much as two degrees by inunctions of oil. The decline begins immediately after the application, the minimum temperature attained remains stationary for two hours, and then a rise begins. The younger the child the more pronounced the fall of temperature. A restless and irritable child falls asleep at once after being rubbed. No directions are given as to the methods employed.—*N. Y. Med. Journal.*

The Spread of Diphtheria.—Prof. A. Jacobi, in an article published in in the New York *Medical Journal*, September 27th, says, in substance, that many sore throats, regarded as trivial, are, in point of fact, diphtheria. The large majority of the cases designated follicular tonsillitis, are cases of diphtheria. What to-day looks like a point, or four or five points covering the outlet of ducts, to-morrow may be a continuous membrane. You might as well withhold the name of variola from a case of small-pox because it is not confluent. You have a family sick with affections of the nose and throat; a child is dying of laryngeal croup; another of nasal diphtheria, glandular swelling and sepsis; others have severe pharyngeal affections; others but slight tonsillar tufts which may or may not coalesce into membrane. Is the first one croup? Are the others diphtheria? Is the last one follicular amygdalitis? Or the first case in a family is called follicular tonsillitis, and no measures are taken to protect the other mem-

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bers. From that time extermination of the family began. All have seen such illustrations. Some mild cases of diphtheria are prolific of danger because they are apt to assume a chronic course without losing contagiousness. A family with children ought to insist upon the occasional inspection of the throats of their help. Servants with chronic pharyngeal catarrh must not be hired. A seamstress coming for an occasional day's work ought to have her throat examined; cooks and nurses must be looked after, the more carefully the less inclined they are to give way to their ailments, or throw up their places. A sick nurse may go from one place to another, and carry pharyngeal and puerperal diphtheria. Thus if there be any class of persons who are likely to transmit the disease, it is domestic help, nurses, teachers, hairdressers, barbers, and all those who are in constant contact with people. There is as much diphtheria out of bed as in it; nearly as much out of doors as indoors. Many a mild case is walking the streets without caring or thinking that some of his victims have already been wept over. There is, probably, no spontaneous origin of diphtheria any more than there is a spontaneous origin of cholera or scarlatina. Diphtheria is contagious. Severe forms may beget severe or mild forms. Mild cases may beget mild or severe cases. What has been called follicular tonsillitis is mostly diphtheria. It is seldom dangerous to the patient, as the tonsils have but very little lymph communication with the rest of the body; but it is contagious. It is frequent in the adult, in whom it proves dangerous to others, because it does not restrain him from intercourse with them.

Koch on the Cholera Bacillus.—In the last issue of the *Deutsche Medicinische Wochenschrift*, Koch replies to his critics, and expresses unaltered confidence in the correctness of his original belief in the specific character of the bacillus. He points out that similarity is not identity. Some germs do possess unmistakable and peculiar features, but in the case of many the possession of other properties than those relating to mere form, is needed to make a distinction. The tubercle bacillus is recognized largely by its peculiar staining reactions. But the best method of differentiation is that which is based on the behavior of the bacteria in cultures under varying conditions of media and temperature, their power of producing spores, and their pathogenic qualities. It is necessary to study these organisms in all their relations before concluding as to identity or difference. The cholera bacilli have many points in common with other micro-organisms, but when all their properties are considered they are seen to be distinct. He maintains that many of those who dispute the specificity of the comma-bacillus do so from incomplete or imperfect methods of investigation. He has received specimens from various sources purporting to contain these germs; but in no case was he able to verify the claim. In the speci-

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mens of curved bacilli and spirilla furnished by Klamann from cases of cholera morbus, neither he nor his colleagues could detect in them any resemblance to the comma-bacillus. He alludes to the statement of Lewis to the effect that curved bacilli, closely *resembling* those of cholera, may be found in buccal secretions, and says that the fact has been known for years. But these buccal bacilli behave differently from those of cholera, in gelatine cultures, and they are larger, more slender, and less blunted at the extremities. Passing to the alleged discovery of comma-bacilli in cholera murbus by Finkler and Prior, he says that these observers did not isolate bacterial forms in their culture experiments, and consequently their specimens contain various kinds,—four of which were differentiated by him. One of these, only, bears any resemblance to the comma-bacillus, but it grows more rapidly in gelatine and on potato; the colonies it forms in gelatine are differently shaped and more granular; it liquifies the gelatine; and it also differs in the effect of temperature on its growth.

He has examined the dejecta of fatal and non-fatal cases of cholera morbus, but found no comma-bacilli. He also examined with like result the stools of a rapidly fatal case of arsenical poisoning. At the Institute there have lately been hundreds of examinations of normal and abnormal stools, the latter from all classes of diarrhœal disorder, but in no case have micro-organisms resembling comma-bacilli been found. He has not, therefore, met with any evidence to disprove the specificity of the latter, and he insists that until such evidence is produced the diagnostic value of the comma-bacillus be recognized. The obstacle to the acceptance of his views, arising from failure to develop the disease by pure cultures, is in a fair way to be overcome. Rietsch and Nicati produced cholera in dogs and guinea-pigs by injecting pure cultures of the bacilli into the duodenum. Koch has repeated their experiments, and with few exceptions the animals died in from twelve hours to three days with choleraic symptoms.

Vaccination Against Yellow Fever.—The researches which have been made during the past two years by Dr. Domingos Freire, seems to be on the point of culmination. The investigator has prepared an attenuated virus, innocuous, with which he proposes to make susceptible persons insusceptible. He has already vaccinated five hundred individuals, officers and crews of British vessels, with a view of protecting them from the infection of yellow fever which prevails at Rio Janeiro. None of the vaccinated people suffered inconvenience from the operation, and thus far none of them have contracted the disease.—*London Lancet*, Jan., 1885.

—Twenty physicians have died in Naples, out of one hundred and twenty-nine, engaged in attending cholera patients, under the White Cross Society, during the recent epidemic.

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Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

The Treatment of Sciatic by Congelation. — Revulsives appear to act upon sciatic neuralgia by exciting the morbid nerve-ends; but the number of these nerve-filaments subjected to the revulsive action, is always too limited. We can not, for instance, apply a fly-blister extending from hip to heel, or cauterize the whole limb, but we can operate this general revulsion by congelation of the skin. The maximum accident possible is the formation of an eschar, but the classic treatment of the sciatic being the application of the cautery, there is nothing to fear in this direction.

Choride of methyle (methylchloroform) produces, by evaporation, a lowering of temperature, bringing the thermometer down to zero (Fahr.); if the evaporation is accelerated by artificial means, a much lower temperature can be produced. Upon our first case of sciatic, a stream of methylchloroform was applied to the whole painful surface, from the hip to the external maleolus. One minute later, the patient, who had not been able to stand since his admission to the hospital, could walk without limping, declaring himself cured. It is three months since, and no relapse has occurred. Numerous applications of the same means have met with the same success. The patients either have healed at once, or have had slight relapses which have yielded immediately to a new application of the methylchloroform. These patients had the simple sciatic, the form called rheumatic, and the affection, always severe, dated from a fortnight to three months. The apparatus used to produce congelation, is a siphon containing the methylchloroform. To the lower end of the siphon, a lead tube and a spout provided with a small orifice are adapted. It is a modification identical with that M. Molossez, used to freeze, by means of methylchloroform, anatomical pieces; it facilitates the direction of the stream without great loss of liquid. Richardson's apparatus does not give results comparable with these.

The stream of methylchloroform is applied to the skin, all over the affected region, from the sacrum to the malleolus. Immediately after, the integument is congealed, blanched and hard as a stone. The patient complains of a burning sensation which is painful, but not to be compared to the pain caused by the white-hot cautery. The skin soon thaws out, however extensive the congelation may be; an erytheme more or less pronounced subsists, and the maximum of the accidents has been a slight vesication and never an eschar. After the freezing process, the patient feels better and able to walk; if one or two painful points persist, a new application to these spots is required.

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This method is also applicable to other neuralgia, or other pathologic conditions where pain is the chief symptom. — *Translation from the French of Dr. Debove in Soc. Médic. des hopitaux.*

Erythroxylon Coca in Diseases of the Skin.—Dr. John V. Shoemaker, at a recent lecture, delivered at the Philadelphia Hospital for Skin Diseases, spoke of the treatment of certain cutaneous affections by the topical application of the fluid extract and extract of erythroxylon coca. The hospital record shows that both preparations had been successfully used, for the past two years, in cases of eczema, dermatitis, herpes, herpes soster, rosacea, urticaria and paræsthesia. A case of acute eczema of the ear and neck was shown which was improving on the local application of one ounce fluid extract erythroxylon of coca to three ounces of water. It was ordered in the same way in a case of dermatitis of both arms. In rosacea of the first stage in which the nose and cheeks were involved, three drachms of the extract of erythroxylon coca was prescribed to one ounce of lard. It was also applied in a case of perverted sensibility of great irritation of the integument of the lower limbs in an old patient brought before the class. The lecturer stated that the fluid extract and extract of erythroxylon coca, which he had employed now for more than two years, had a most decided sedative action upon irritable conditions of the integument, used either alone or combined with other suitable remedies which may be indicated. — *Med. Bulletin of Med. and Surg.*, Dec., 1884.

Hydrochlorate of Cocaine.—This new preparation which has only recently been brought before the profession, promises to come into general use as a local anæsthetic of decided value and universal applicability. The first clinical experiments with it were made by ophthalmic surgeons, who succeeded in producing complete insensibility of the cornea and conjunctiva. Since then its merits have been tested by prominent observers in other special departments with uniformly gratifying results. It is being used to lessen the sensibility of the larynx for purposes of examination and operation, as well as in urethral affections. Tracheloraphy is said to have been performed without ether, and without pain through its use. Tympanitic neuralgia and tinnitus aurium, which baffled previous treatment, have been relieved by its instillation into the ear.

Dr. Bosworth, of New York, also claims for it the power of contracting the nervous sinuses in the nasal mucous membrane, rendering operations there not only painless, but also reducing the bleeding to an almost trivial amount.— *Med. Bulletin*, Dec. 12, 1884.

Activity in an Old Vaccine Crust.—A remarkable instance of the preservation of the activity of a vaccine crust, is related in a recent issue of the *North Carolina Med. Journal.* It seems that during the term of

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office of the Hon. Willis Alston, grandfather of Dr. Alston (as a congressman from North Carolina from 1803 to 1825), Dr. James Smith, of Baltimore, was Director of the Vaccine Institution for the State of Maryland. He sent to Dr. Alston a package of vaccine, and it remained unopened until it fell into the hands of his grandson, Dr. Alston, in May, 1869. It was a crust imbedded in wax, and enclosed in a wooden box. The doctor vaccinated his servant with a part of the crust, and "in due time," it took effect, leaving a well defined scar.

The Microbe of Yellow Fever.—At a recent meeting of the Paris Société de Biologie, M. Rebourgson gave some additional information as to the researches of Prof. Domingo Frére, of Rio de Janerio, on the microbe of yellow fever. He believes that a former communication to the Academie de Médicine has not met with due attention. M. Frére, he observes, is fully entitled to priority in his discovery, the reality of which is shown by the fatality which attends the inoculation of the microbe in animals, which is very easily brought about. A still more important result is the attenuation of the virus by means to be hereafter divulged; inoculation of this attenuated matter only produces temporary disturbance of the animal's health. Informed of the experiments, the Emperor of Brazil ordered that 600 workmen, constantly occupied in the midst of highly infected districts, should be inoculated. While before this period ten men out of every thirty had been attacked with the disease, none of those inoculated have suffered, except four or five men, on whom the operation was performed by the lancet instead of by the Pravaz syringe. M. Bouley drew attention to the importance of giving the widest publicity to these statements, and stated that the attenuated virus was about to be taken to Senegal, where last year twenty-three out of twenty-five French physicians died of yellow fever.

Remedy Against Distressing and Fatiguing Coughs.—Take one ounce and a half or two ounces of pure glycerine and evaporate in a porcelain capsule, by means of a spirit lamp. An enormous amount of vapor is disengaged, which inhaled, brings relief to persistent coughs.—*Revue Médicale.*

Lusk's Aperient Pills.

℞	Ext. aloes socot.	℈i.
	Pulv. rhæi	gr. x.
	Ext. nuc. vom.	gr. v.
	Ext. tarax.	ʒss

M. Fiant pil. No. XX.
S. One before meals.

Lotion for Dandruff.

℞	Tinct. capsic.	2 p.
	Glyc.	8 p.
	Cologne	2 p.
	Aq.	25 p.

M. S. Apply, by means of a sponge, to the scalp, every day.

The Physician as a Father Confessor.—Queen Isabella of Roumania, wrote some good epigrams, recently published by *The Century Magazine*,

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wherefrom, the following, referring to the profession, is reproduced: A physician is a much better confessor than a curate. A penitent says to the curate: "I abhor humanity," he contests it. "It is not Christian-like." The physician gives him a dose of rhubarb, and 48 hours after, he loves his fellowmen as much as he hated them before. Another individual confesses to the curate: "I am tired of life," he demonstrates to him the criminality of suicide. The physician prescribes him a tonic, and 24 hours later, life is a paradise to him.

Treatment of Chloroform Syncope Produced During Anæsthesia.—Dr. Garland, in the *British Med. Journal*, (April, 1884) reports a case of chloroform narcosis, which occurred, during anæsthesia, to a lady aged 41, who was about to be operated on for a cancer of the breast. Suddenly, during the administration of chloroform, the patient became livid and the pulse ceased to beat. Artificial respiration and stimulants were immediately used, but to no avail. In this emergency, Dr. Garland climbed upon the table and grasping both feet of the patient lifted her up in the inverted position, so that her head, the lowest part of the body, rested upon the table; a few seconds later, the color returned to the lips and the pulse was felt at the wrist. The anæsthetic was resumed, and again respiration and circulation suffered as before. Electricity was now resorted to, but in vain; suspension by the feet was repeated, and the same success was reobtained. This method of inversion of the body, in case of chloroform narcosis, was proposed by Dr. Holmes, in 1868. As it has not received the sanction of the majority of the profession, it were better to investigate its value as a therapeutical agent.

Laryngology.

Edited by GEO. F. HAWLEY, M.D., 125 State St.

Acute Coryza.—Dr. Dobell of London recommends for acute coryza, 5 grains of carbonate of ammonia with 5 m. of liquor morph. (B. P.) in 1 ounce of almond emulsion, every three hours. At night ʒiss of spirit mindererus must be taken in a glass of cold water after the patient is well covered in bed. If desired, cold water can be given freely during the night. The extra blankets should be gradually removed towards morning, thus allowing the body to cool before rising. The ammonia mixture should be continued during the second day every four hours, and at night a compound colocynth pill is to be given. No change as to diet is necessary, and usually about twelve doses are sufficient for a cure. Should, however, the cold return after a discontinuance of the medicine, another six doses should be given with another pill at bed time. Patients are not

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required to remain at home while under treatment, as there is no predisposition to a fresh cold, which is so common after the usual treatments by hot drinks, dovers powders, etc.

Robinson recommends, in addition, the following:

℞.	Pulv. belladon.	gr. xx.	
	Pulv. morph. sulph.	gr. ii.	
	Gum acac. *ad.*	ʒss	M.

This is used freely as a snuff during the day.

A New Method for Curing Crooked Noses.—An operation for straightening a crooked nose, due to nasal fracture, was reported by Dr. John B. Roberts, at the Philadelphia Counnty Medical Society. The party operated upon had obstruction in the left nostril, due to the nose being bent to the right, the result of a fracture.

With a scalpel introduced into the left nostril, the cartilaginous septum was perforated at its upper and back part. A long incision was then made through it, downwards and forwards. This allowed the whole cartilaginous portion of the nose to be pushed to the left, overcoming to a great extent the lateral deformity. To retain the parts in position, a steel pin about one and one-fourth of an inch in length, was introduced into the right nostril and passed completely through the anterior and upper segment of the divided septum, near the columella. By carrying the head of the pin towards the left, the anterior part of the nose was likewise moved to the left, where it was retained by imbedding the point of the pin into the septum and mucous membrane covering it, at the posterior part of the left nares. In the case related there was found, after the operation, a slight deflection of the end of the nose to the right. This was rectified by separating the cartilage from the right nostril by a tenotome without perforating the skin. A pin inserted from the cutaneous surface on the right of the median line, held the nose in position, the point of the pin being forced into the tissues of the left nares. The pins are left in position about two weeks. Free incisions are necessary for good results.

Hay Fever. — In an article by Carl Seiler, M.D., in the *Phila. Med. Times*, of Dec., entitled Reports on Laryngology and Diseases of the Nose, he states that the disease known as hay fever, which is so prevalent in America and England, has excited quite an interest of late among the general practitioners, due to the many reported cures by means of the galvano-cautery. Previous to the introduction of surgical interference various kinds of snuffs were employed to destroy, as was claimed, the pollen grains which had taken up their abode in the nostrils of those unfortunate individuals. Helmholtz and Salisbury recommended solutions of quinine, ascribing the disease to vibrios and animalculæ. This treat-

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ment, however, was merely palliative in its action, and no lasting good could be obtained except by removing the patient to a locality free from the particular germ which was supposed to cause the disease. This locality could only be found by trial. While in some cases hay fever would disappear in the clear air of the mountains, others could find relief only in the smoky atmosphere of cities like Pittsburgh or London. Dr. W. Daly, of Pittsburgh, and Dr. J. O. Roe, of Rochester, were among the first to bring into notice the benefit obtained by employing the galvano-cautery upon the hypertrophied and peculiar sensitive mucous membrane of the nose, which seemed to be associated with this trouble. Numerous cases have been reported as cured by the destruction of this hyper-sensitive mucous membrane lining the terbinated bones. Since then laryngologists both here and abroad have published papers in which they uphold the theory of Roe and Daly, and added their experience as to the effectiveness of the treatment. A difference of opinion regarding time of operation, whether it should be during or after the attack, is held by some. The author states that when he operated before the onset of the disease, the attack was either prevented or greatly modified in severity; but that no benefit was obtained when the attack had set in. On the contrary, the symptoms were generally aggravated. Our experience is the same with one exception, when the operation was performed under the new loco-anesthetic muriate of cocaine. Here the galvano-cautery was used while the patient was under the full power of the disease. The muriate of cocaine prevented the sneezing which is so readily excited at this time, and greatly lessened the reaction and inflammation which generally follows the use of the hot wire. The attack was cut short and did not return.

Our experience with the vaseline treatment of Rumbold, of St. Louis, as described by him in the *Weekly Med. Review*, has thus far been unsatisfactory. While it gave temporary relief during the attack, we cannot remember a single case where we could discover any permanent benefit. Furthermore, patients objected strongly to adopting the rules given by him regarding self-treatment and habits of living. Though we are willing to admit our failure may be due to this fact, still the results of operating by the cautery have been so flattering not only in our hands but in others, that we are led to prefer this method. That this operation can be credited to American laryngologists we think can truly be said, when Makenzie, of London, passes it by unnoticed in his second volume on Diseases of the Throat and Nose.

Muriate of Cocaine in Laryngeal Surgery.—In the Dec. number of the *Birmingham Med. Review*, Christopher J. Lewis, M.D., published in a paper his experience in the use of cocaine in various operations about the throat. While at Vienna he had daily opportunities of watching the

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effect of this drug, at the cliniques of Prof. Schroetter when employed by the Professor and Dr. Jelinek. Polypi and papillomata were removed from the larynx of patients without any previous and prolonged training, in order to tolerate the instruments necessary to be used in such cases.

The strength of the drug in ordinary cases, as recommended by Jelinek, is 10 per cent. solution, and when the full effect is required, as in operative treatment, 20 per cent. is used. This is, as a rule, a much stronger solution than is used in this country, 4 per cent. solution being generally employed, though Dr. F. G. Knight, of Boston, advocates the use of a solution as strong as any used in Vienna, it being a 20 per cent. solution. Such a strength he finds will abolish all reflex spasms.

Dr. J. Solis Cohn in his published cases, while using only a 4 per cent. solution, states that although the patient was barely conscious of the presence of a probe he placed upon the vocal cords, the spasmodic contraction of the laryngeal muscles shut the interior of the larynx out of view as completely as if no anesthetic had been used. The same occurred in one other case which he reported. He further states that he never has been able to prevent this reflex spasmodic reaction by the use of this remedy. While a comparative weak solution may destroy the sensitiveness of the parts, and may be sufficient for operations about the nose and pharynx, a much stronger solution must evidently be used in all endo-laryngeal operations, to prevent reflex spasms. Without this we lose all the advantages offered by this drug for such operations, viz.: a clear and open view of the inter-laryngeal spaces. The drug is to be applied by means of a small swab, made of absorbent cotton, to the pharynx, while to the larynx a thick soft brush is preferred. The solution is to be applied to the whole surface of the mucous membrane, which is to be tested to see if the anesthesia is complete. If not, another application is needed. If too free an application be made it may cause an excessive flow of mucous which will retard the action of the drug. It is better also to wipe carefully the surface of the mucous membrane before applying the cocaine.

The author states "that an alcoholic solution should not be used when dealing with an inflamed surface; the alcohol becomes an irritant under these circumstances." The formula used in Vienna is cocaine mur. 1 gramme, spt. vini rect. 2 grammes, aq. distil. 3 grammes.

Dr. Lewis ends his paper by saying that the uses of cocaine are:

1. To facilitate the use of the laryngoscope and rhinoscope, and so to aid diagnosis.

2. To ease pain and reduce swelling in acute affections of the pharynx and larynx.

3. To relieve the dysphagia due to tubercular perchondritis, or where due to ulceration, from whatever cause, of the posterior laryngeal wall.

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4. To anæsthetize the larynx for the performance of endo-laryngeal operations.

In laryngeal phthisis in which there is great odynophagia, due to an inflamed and swollen epiglottis. Muriate of cocaine has proven of great service. Patients who were unable to swallow on account of the severe pain, have by the use of this remedy succeeded in taking food with perfect ease. The drug is to be applied over the swollen epiglottis, ten minutes before attempting to swallow.

Partial Laryngectomy.—At the recent meeting of the German Surgical Association, Hahn, of Berlin, recorded five cases of laryngectomy for carcinoma, the entire larynx having been removed in three, and one-half of that organ in two. Of the former, two died of suppurative bron chitis and pneumonia in the fourth and fifth week, and the third was still living at the end of three months. Both of the latter recovered and were free from recurrence, respectively, at the end of three years and a half, and nine months. They were wearing a simple canula, and were comfortable, and made themselves so readily understood that they refused to have the wound closed. Hahn is a strenuous advocate of removing only one-half of the larynx where the limited extent of the disease admits of it. Total extirpation has resulted in twenty-four deaths out of fifty-two cases, while removal of one-half of the larynx has terminated fatally once out of eleven cases. Not only is the latter operation more safe, but it is less frequently followed by recurrence, and the functional results are so much better that the canula can be dispensed with in the majority of instances. In the discussion elicited by the reading of the paper, Hahn found two warm supporters of his views in Schede, of Hamburg, and Küster, of Berlin. Schede's patient was living eighteen months after excision of the right half of the larynx for carcinoma. He had ceased to wear the canula for nine months, and his articulation was distinct. Küster's operation was for sarcoma, but the speech was hoarse and less clear than in Schede's case. Unfortunately, the time that had elapsed since the operation is not stated.—*Philad. Med. News*, July 12, 1884; *London Practitioner.*

In the nineteen cases reported by Mackenzie, of London, of extirpation of the larynx there were but three in which there was partial laryngectomy. Of these, one had a recurrence after six months, another died on the fifth day after the operation, and the third died from a recurrence at the expiration of seven months. The first was an example of epithelioma, and the others of carcinoma. Of the remaining sixteen three were cured, one of which died eighteen months after the operation from pulmonary and tracheal phthisis. In these three cases the disease was absolutely confined to the larynx.

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Epistaxis. — Voltolini, of Breslau, (*Revue Mens. de Laryng. etc.* Oct.) writes concerning epistaxis. The substance of his article is that the arrangement, direction and enormous number of blood vessels in the erectile tissue of the nose, explain the hemorrhagic tendency of the organ, and that with proper instruments and light, it will be discovered that some of the worst cases of nose bleed have their origin in a pathological area not larger than the head of a pin. In a case which had resisted the treatment of surgeons at Leipzig, Vienna and Dresden, he discovered the bleeding point to be a small granulation, resembling a minute angioma, in the middle meatus, and destroying this with a galvano-caustic point, completely cured the despairing and long suffering patient. A quite frequent source of recurrent epistaxis is from a pin head erosion (often made by the finger nail in picking the nose) in and near the anterior inferior border of the cartilagenous septum. It suffices but to cauterize the little ulcer with a red heated electrode.—*St. Louis Medical and Surgical Journal.*

Dr. Little, of New York, in the *Hospital Gazette*, N. Y., 1879, v. 1, 5, reports four cases of epistaxis. In these cases the bleeding came from a small artery located in an erosion on the septum, about half an inch above the columna. Hemorrhage was arrested by touching the bleeding points with the muriated tincture of iron in one case, while the nitrate of silver was equally as successful in the three remaining.

Dermatology.

Edited by HENRY J. REYNOLDS, M.D., 2200 Michigan Ave.

Miliaria and Sudamina.—At the last meeting of the American Dermatological Association, Dr. A. R. Robinson read a paper on this subject. He first quoted the opinions of various authors on the essential nature of these eruptions, usually described under a variety of names, such as miliaria alba et rubra, eczema solare, lichen tropicus, prickly heat, sudamina, etc., and showed that they conflicted greatly. The object of the paper was to clearly define the real nature of the affection, and the conclusions reached were based upon careful microscopical study of the lesions. A number of drawings, illustrating the pathology of the affections, were exhibited. The author of the paper found that the papules and vesicles in miliaria, alba and rubra (prickly heat) were due to an exudation into the rete mucosum around the orifices of the sweat-ducts, composed of serum, corpuscles and some sweat (but never of the latter fluid alone). The changes in the rete were similar to those met with in eczema, and the exudation came from the vessels of the papillæ. A catarrhal condition of

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the sweat glands was also often noticed. He concluded that miliaria alba et rubra was not an inflammatory affection of the sweat-glands, but one of the skin, especially around the duct orifices. Sections through sudamina (the "dew-drop eruption") had revealed the facts that the vesicles were always formed in the corneous layer, and that they were in direct communication with the sweat-ducts. The rete around the vesicles was normal, and their contents were always sweat. The glands and ducts seemed normal. The disease was therefore not an exudative affection, as maintained by Hebra, but consists in an increased production of sweat (the result of hyperæmia), together with some obstruction to its escape, caused ordinarily by detached or stretched epithelial cells. He therefore concluded that milliaria alba et rubra was a form of eczema, or catarrhal inflammation of the skin, due to heat, irritating clothing, acrid sweat, etc., and was situated in a sweat-duct orifice area, as that was the part most hyperæmic or deranged in circulation in prickly heat, and that sudamina was not an exudative affection, but was solely due to a disturbance of the sweat-glands and corneous cells, the result of a hyperidrosis, etc. He thought that the term miliaria should be dropped, and that the name sudamina should be applied to the lesions of the dew-drop eruption.—*Jour. Cut. and Vener. Diseases*, Vol. 2, Dec.

Benign Epithelioma of the Face.—Chlorate of Potash.—Dr. Lèvêgue, in a thesis quoted in the *Glasgow Med. Jour.*, gives the following description of "benign" epithelioma:—It is a slight local affection, appearing usually in patients of advanced age; of glandular (sudoriporous) or papillary origin; it is first noticed as a tubercle or wart, surrounded by a fibroid or fibrous membrane, in which it lies encysted. At the end of a variable period, lasting from two to thirty years, it presents a depressed or excavated ulceration, which exposes the whole lesion. There is no glandular enlargement, at least for many years. The radical cure is possible during the whole period of encystment, but when the epithelial proliferation, passing beyond the fibrous barrier which encloses it, invades the skin, the case takes on a graver aspect, and the chlorate of potash must give way to the knife. The treatment of benign epithelioma may be managed in the following way: The ulcerated part must be touched as frequently as possible with a 10 per cent.-solution of chlorate of potash in glycerine, and covered with lint smeared with simple ointment. Treatment may last three months, but improvement is manifest at the end of two weeks. If, at the end of three weeks, there be no marked amelioration, the knife must be resorted to.—*Med. and Surg. Rep.*

Chrysarobin Internally in Skin Diseases.—Dr. Stocquart reports sixty-one cases treated by internal administration of chrysophanic acid (*Annales de Derm. et de Syph.*, Jan. '84). No form of local treatment was em-

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ployed. Of the sixty-one cases fifty-six were entirely cured, and only one was unaffected by the treatment. The cases of acne, ecthyma and impetigo all yielded rapidly to the treatment, except one case of papulous acne. One case of pityriasis and three of urticaria were also quickly cured. In four cases of lichen and four of prurigo the irritation was rapidly diminished, disappearing before the complete cessation of eruption in lichen. Of thirty-two cases of eczema, thirty were cured. The author was struck with the rapid and complete cure of acute eczema and of impetiginous eczema in children. Out of five cases of psoriasis, three were cured. The acid was generally administered in water, the bottle being well shaken before use. In ordinary doses no patient objected to it; it was also prescribed in pills. The medium dose is one centigramme a day for children, and three centigrammes for adults. In these doses it is generally well tolerated; in large doses it may cause loss of appetite, nausea, palpitation, with præcordial distress and constriction of epigastrium, giddiness, vomiting and cold shivers. This is an occasional only, and often much larger doses are well borne. Children tolerate the medicine well; at four weeks he has given one, two, and in one case five centigrammes, without provoking gastric irritation. Where the eruption is limited to parts ordinarily covered, and where the skin is not very thin or delicate, the external use of chrysophanic acid as an ointment is indicated; where a great extent of surface is involved the internal use is better. Phenomena of local irritation or erysipelas, or gastro-enteric symptoms or nephritis, may be caused by the too free external use of the acid. Its internal use is also indicated when the eruption affects the hands or face. Where the stomach will not bear the remedy it may be given hypodermically, but is then apt to cause pain and abscess. Its action is more rapid than when given by the mouth.—*N. Y. Med. Jour.*

Oleate of Bismuth in Eczema.—

℞	Bismuthi oxid	ʒi	
	Acidi oleici	ʒi	
	Ciræ albæ	℈iii	
	Vaseline	ʒix	
	Ol rosæ	m ii	M.

Its action in eczema of the hands is particularly satisfactory.— *Van Harlingen, in Phila. Med. Times.*

—A change of air is less valuable than a change of scene; the air is changed every time the direction of the wind is changed.

—Calisthenics may be very genteel and romping very ungenteel, but one is the shadow, the other the substance of healthful exercise.—*Frank H. Hamilton, M.D.*

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Treatment of Ringworm.—Alder Smith, F.R.C.S., London, writes, in the *Brit. Med. Jour.*, on this subject as follows: I have been trying for some time to find out what vehicle penetrates most deeply into the hair-follicles, and I think it is chloroform. Chrysophanic acid is a very good parasiticide; and, though it is insoluble in spirit and ether, yet it is soluble in chloroform. Chloroform also dissolves the fatty matter out of the hair follicles, and thus allows the parasiticide dissolved in it to penetrate deeply. During the last year I have used a solution of seven grains of the acid to the ounce of chloroform to all cases of recent ringworm, and believe it is the most efficient treatment I have yet tried. The small patches should be carefully marked out by cutting the hair very closely on them, and the chloroform solution should be well pressed and dabbed into the places with a minute sponge-mop for five minutes two or three times a day, according to the amount of irritation produced. The aim of the treatment is not to produce scabs, but to get the solution to penetrate deeply. The sponge-mop should not be much larger than a big pea, and should be continually dipped into the chloroform bottle, as the solution soon evaporates while it is pressed into the diseased spot, and leaves the yellow acid dry on the place. Great care must be taken that the solution does not run onto the forehead or into the eyes, and that the person using it does not inhale the vapor. I always give full directions about the care necessary in using such a potent remedy, and only apply it to small places of the disease. It is well for the nurse to keep her face away from the sponge, and to use the chloroform in a current of air and not in a small room. The places should be washed every morning with hot water and soap, to remove any sebaceous matter or crusts, and the hair should be kept closely cut on them till the new hair appears, which is generally in about two or three months; but the remedy should be continued till all diseased stumps have come out.—*Med. Age.*

Liver Spots.—In an article on tinea versicolor, or liver spots, the *Med. and Surg. Rep.* says: The treatment is not difficult. The sulphur preparations are all useful, such as sodium hyposulphite, one drachm to the ounce of water; or Velminckx's solution, which is prepared as follows: quicklime, one-half ounce; flowers of sulphur, one ounce; water, ten ounces. Boil down to six ounces and filter; perfume with oil of anise. This may be used diluted with four to eight parts of water, to be dabbed on the patches after a bath with soap and water. At the end of a week scarcely any sign of the disease will remain, and at the end of two weeks a cure may be effected. The result depends largely on the manner of making the application.—*Canada Lancet.*

—The loneliest doctor in the world is the ophthalmologist who has made no report of experience in the use of cocaine.—*Medical Record.*

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Surgery.

Edited by G. FRANK LYDSTON, M.D., 125 State St.

The Treatment of Stricture of the Urethra by Internal Urethrotomy, with a Review of the Different Methods.*—There can be no difference of opinion with regard to the danger of neglecting stricture of the urethra; retention of urine, perineal fistulæ, cystitis, and suppuration in the kidneys are the most serious, and at the same time the most common consequences. Besides obviating these possible evils, we are often called upon to interfere in order to relieve the pressing symptoms of stricture and to prevent their recurrence; and I propose to explain what I believe to be the best means for attaining these ends. I do not intend to discuss the symptoms or the diagnosis of stricture; my remarks will be confined to the various methods that may be employed for effecting a permanent or radical cure. By this I mean the restoration of the strictured portion of the urethra to its normal calibre, in such a manner that the improvement will be not temporary but permanent.

Many methods have been and are still employed; the most important of these are four in number, namely, dilatation, rupture, external and internal urethrotomy. With regard to dilatation, either gradual or continuous, it is of course the simplest and the safest method, and it should always be first tried; but it is often found inefficacious for old standing indurated strictures for those which are characterized by resiliency and for strictures of traumatic origin. The second method, rupture or divulsion of the stricture, is open to many objections. With the ordinary instrument the stricture can not be lacerated or split without the risk of tearing, at the same time, the healthy portion of the urethra. Besides, it is impossible to estimate the extent to which the stricture has been split, and if much force be used, the laceration is likely to involve the deeper tissues of the urethra. Another grave objection is constituted by the fact that in neglected cases the cicatrices, after Holt's operation, give rise to contractions as resistant as strictures of traumatic origin.

We now come to the methods which involve incision of the urethra, and, first, as to the external urethrotomy. In this operation, to which the late Mr. Syme's name has been attached, a staff is passed through the stricture, and upon this, as a guide, an incision is made from the perineum. The results of this operation, so far as can be gathered from statistics, are in general very satisfactory, but it should, I think, be reserved for severe traumatic cases, and for cases complicated by perineal fistulæ and abscess. A less serious operation, and one in which only the dis-

*Read in the Section of Surgery, by Walter Coulson, F.R.C.S. Eng., Surgeon to the Lock Hospital, etc.

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eased parts are dealt with, is much more generally applicable. To put the case briefly, I would say that, with the exceptions just mentioned, internal urethrotomy should be performed when the method by dilatation is impracticable, and also when retention recurs in spite of dilatation.

I now therefore come to the immediate subject of this paper, and I propose to describe the operation of internal urethrotomy (as practiced at the hospital with which I am connected), to allude to the results of the operations, and to review the different methods of performing it.

Internal urethrotomy can be performed in two ways; that is to say, the stricture can be incised from behind forwards, or from before in a backward direction towards the bladder. Each plan has its advocates, and it must be admitted that extremely good results have been attained by both methods. Still, as I shall presently attempt to show, the division of the stricture from before backwards is, for several reasons, to be preferred to the other plan.

At St. Peter's Hospital we are accustomed to use the urethrotome known as Maisonneuve's, but modified and improved in various ways by Sedillot, Gouley, and in particular by my colleague, Mr. Teevan. The instrument consists of a grooved staff, which is introduced into the bladder. A triangular blade, with a stilet attached, is made to slide along the groove, and the blade is contained in a double sheath, from which it is protruded when the stricture is reached. In Masonneuve's original instrument the blade was furnished with a knot, and the groove extended to the end of the staff. The groove in this instrument terminates two inches from the end; it is likewise fitted with a wire stilet, on the withdrawal of which urine will flow if the instrument be really in the bladder. The knob on the blade is replaced by the double sheath which encases the knife. The instrument terminates in a small screw by means of which it can be attached to a conducting bougie which guides it into the bladder. Before making the incision it is of great importance to be quite certain that the instrument is really in the bladder, for in the absence of such proof a false passage might be divided instead of the stricture. After this instrument has been passed the stilet is withdrawn, and urine will then escape if the bladder have been reached.

The operation is performed at St. Peter's Hospital in the following manner. A fine flexible guiding bougie equal in size to No. 4 or 5 F. is passed into the bladder. The staff or sheath of the urethrotome is then screwed on to the guide, passed through the stricture into the bladder, and held in position by an assistant. The operator with his left hand seizes the penis just behind the glans and draws it forward; with his right hand he pushes the stem of the sheathed knife down the urethra until the obstruction is reached; the knife is then protruded, and all re

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sisting tissue in front of it is divided. The incision is thus made in the roof of the urethra. The knife is then withdrawn into its sheath which is pushed along the urethra in order to ascertain that the division has been complete. If it be so, the instrument is immediately withdrawn. A full sized silver catheter is then passed; the bladder is emptied, and the catheter is at once withdrawn.

It occasionally happens that some difficulty is experienced in the introduction of the catheter after the operation. In some cases this is due to the staff having been held too far out by the assistant so that the strciture is not completely divided. But this difficulty will not be experienced if the sheath be found to pass freely through the stricture after division. If it meet with an obstruction the incision must be repeated. The passage of a full-sized silver catheter suffices to prove that the calibre of the urethra has been restored to its normal dimensions.

With regard to the after-treatment, the ordinary course is as follows: Immediately after the operation (the patient, of course, remains in bed) hot bottles are applied to the feet, and three grains of quinine are given with half an ounce of brandy. A little warm beef tea is also given from time to time. If no rigors occur the patient has a hot bath at night, and forty-eight hours afterwards a French bougie corresponding in size to the catheter used after the operation is passed along the urethra. The patient is then allowed to get up. The bougie is passed every three or four days, and at the end of ten or fourteen days the patient is taught how to use the instrument himself. When he is able to do this satisfactorily he is discharged and attends as an out-patient, with instructions to use the catheter once a week. He is kept under observation for as long a period as he can be induced to attend.

The next point refers to the results of the operation, and these I think are very satisfactory. The house-surgeon at St. Peter's Hospital has prepared a list of 206 cases of stricture for which internal urethrotomy has been performed during the last ten years. I will mention only a few of the results shown by an analysis of this list. The ages of these 206 patients varied from 16 to 69 years. Only four were under 20; the decade from 30 to 40 gave the largest number of cases. In a large proportion of the cases the strictures were of a severe form. In twelve they were of traumatic origin. Ten cases terminated fatally, but two of them died from causes unconnected with the operation, for one patient succumbed to bronchitis, and in another death followed lithotomy, which was performed twenty-one days after the patient had been subjected to internal urethrotomy. In a majority of the eight cases in which death was attributable to the operation, the fatal result was immediately due to suppression of

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urine. Collapse and signs of pyæmia were the symptoms that preceded death in the remaining fatal cases.

We next have to inquire into the results of the operation as regards the condition of the stricture. Are the effects permanent or are the symptoms likely to return? I believe that a permanent and radical cure will result, provided that the stricture have been sufficiently divided to allow the introduction of a full sized instrument, and the patient has learned the art of passing the bougie himself. Whenever circumstances permit the surgeon should pass a steel instrumeut from time to time. If, in spite of these precautions or as a consequence of neglect the symptoms reappear, the operation can of course be repeated.

I operated last week upon a patient for whom I performed the same operation two years ago. The case was one of traumatic stricture, and the first operation was immediately successful, but the patient neglected the instructions given him; he never attempted to pass an instrument, and the stricture recurred.

A few words with regard to the use of anæsthetics when internal urethrotomy is performed. In the 206 cases referred to, ether was given in 52 instances and chloroform in 3. Among the last 62 cases contained in the list anæsthetics were found necessary in four cases only. The operation is by no means a very painful one, and the absence of an anæsthetic considerably lessens the risk to the patient. Cases for which anæsthetics are most needed are those in which the constricting portion is very dense, and the patients are of decidedly intemperate habits. Such patients bear pain badly; they nearly always struggle, and a comparatively simple operation is thus rendered somewhat dangerous. In any case, however, where there is likely to be anything more than the slightest resistance on the part of the patient, an anæsthetic should be given.

The possible accidents of the operation are few in number. Of the 206 cases referred to, hemorrhage occurred in 15. This, however, is readily controllable if the operation have been performed upon the anterior portion of the canal, and it is at all times less likely to happen if, as I have recommended, the roof of the urethra be divided. Rigors and urethral fever are somewhat common; their occurrence was noticed in 61 cases. A few grains of quinine given immediately after the operation would appear to lessen the severity of this complication. Extravasation of urine has not occurred in any of my cases. Suppression of urine is the most formidable accident. In five cases it was incomplete or partial; in two it was complete, and fatal in its results. In one of these cases on *post mortem* examination the kidneys were found to be enlarged (nearly twice their normal weight) and congested, and to contain purulent fluid in their interiors. The ureters were dilated and full of pus; the bladder

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was inflamed and hypertrophied, and contained only a small quantity of dark purulent fluid. The record of the urine as examined a week before the operation, states "urine 1016, acid, no albumen."

With regard to the circumstances which forbid the operation of internal urethrotomy, all I need say is that it is contraindicated if severe renal mischief be shown to exist. I should hesitate to operate upon a patient with decided symptoms of pyelitis, or on one whose urine contained albumen and hyaline and granular casts.

I have thus described the operation and its results. I wish, in conclusion, to point out the advantages which my method of operating possesses as compared with the plan in which the incisions are made from behind forwards, as with Civiale's instrument and its modifications. This latter method has, as you doubtless know, been recently advocated by Sir Henry Thompson, in his lectures delivered at the Royal College of Surgeons of England. In his operation the stricture has to be dilated up to No. 5 English before the urethrotome can be passed. The bulb of the instrument is introduced through the stricture, and passed half or three-quarters of an inch beyond, but no portion of the instrument reaches the bladder. This incision is made from behind forwards on the floor of the urethra. The preliminary requisite of anæsthesia, and the retention of a catheter for forty-eight hours after the operation are the remaining distinguishing features of Sir Henry Thompson's plan.

There is no doubt that in Sir Henry Thompson's hands his method of operating has proved very satisfactory, but to use Civiale's instrument with safety and success requires a man who has had a large experience, and enjoyed very special opportunities. Even under those circumstances there are, I maintain, several objections to the instrument and the operation. In the first place I am not prepared to admit that all strictures suitable for internal incision can be sufficiently dilated to admit an urethrotome with a bulb of a diameter of No. 5 (English). As a matter of fact strictures of traumatic origin and strictures attended with much induration can not be sufficiently dilated. But the bulb of Civiale's urethrotome can not be passed behind the stricture unless considerable dilatation is feasible. Teevan's instrument, on the other hand, can be passed through very tight narrow strictures. In the second place, having passed Civiale's instrument down the urethra you can not be quite sure as to where the instrument has really gone. It may, for example, be in a false passage. With this instrument of Mr. Teevan's, if urine flow when the stilet is withdrawn you know that you are safe, and in my opinion no man should perform internal urethrotomy for the cure of stricture unless he have positive proof that the instrument he employs has passed through the stricture and is in the bladder. The third objection

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to Civiale's instrument is that with it the operator cannot tell where the incision is to stop. With Teevan's urethrotome you know not only where your incision will begin, but also where it will end, *i. e.*, as soon as all the constricting tissue has been divided.

With regard also to certain other details of the operation I think that the method I have just described is preferable to Sir Henry Thompson's. Thus I think it safer to make the incision along the roof of the urethra than along its floor. There is less bleeding and less risk of extravasation of urine. I have indeed noticed bleeding only in those cases in which the incision was made in the floor of the urethra. I also prefer to operate without placing the patient under the influence of an anæsthetic. As I have said before, the pain is slight; the operation requires only a few seconds for its performance, and it is also well to avoid, when possible, even the slight risk involved in the use of ether or chloroform.

In the last place, I can not regard the retention of a No. 12 or 13 gum elastic catheter for forty-eight hours after the operation as a necessary or safe practice. To say nothing of the discomfort to the patient surely the risks of cystitis, rigors, and of urethral fever must be increased by the retention of the catheter. My practice is to empty the bladder after the operation; some hours will then elapse before any amount of urine accumulates, and by that time the cut surface will be covered with a clot, and the patient will be able to pass his urine with comparatively little discomfort. This point with regard to the non-retention of a catheter, was especially insisted on by Mr. Teevan in a paper he read before this Association a few years ago.

These, then, are the advantages which I claim for the one as compared with the other operation. My remarks are based upon my own experience and that of my colleagues, and I am tolerably confident that my future experience of this operation will tend to corroborate the views I have just expressed.—*British Medical Journal.*

Compound Fracture of the Skull, Escape of Brain Substance, Recovery.—Permit me to give a few details of a case that occurred in my practice between three and four months ago. R. B., æt. four years, while playing on the lower steps of an outside basement stair at the rear of the dwelling, was struck on the head in the right frontal region by a brick which fell from a second story window, a distance of eighteen feet. The child fell but rose again almost immediately, ascended the stair and was finding her way into the house when met by her mother.

I saw the case a few minutes after the accident. The child had vomited two or three times before I arrived, but showed no other symptoms of having received a severe injury. On examination, I found a scalp wound about an inch and a half in length, which had bled freely, and amongst

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the hair a quantity of brain matter, in all about the size of a large marble. The mother had previously wiped a quantity of blood and brain matter from the wound. In the then excited state of the child, I found it impossible to make a proper examination of the wound, or with any degree of safety to ascertain the extent of the fracture, without the use of an anæsthetic. I therefore sent for Dr. Stewart, of Palmerston, to assist me, and in the meantime placed the head in the position most favorable to drainage; applied cold to the head by means of iced water conducted through a bladder by rubber tubes of entrance and exit, provided with stop-cocks to regulate the supply. And as there were no symptoms of depression or shock, except perhaps the vomiting, I gave a sharp purge of calomel and jalap. On the arrival of Dr. Stewart we chloroformed the patient, and on examination found the fracture to be about one inch longer than the scalp wound and situated three or four lines lower on the frontal bone, owing probably to an oblique position of the head when struck. There still remained debris of brain matter between the edges of the wound, and on closer examination, the strongly pulsating torn end of an artery (a branch of the anterior or middle meningeal, most likely the latter), which had been ruptured by the injury, was seen projecting from between the edges of the fracture. The lower edge of the line of fracture was found depressed the entire thickness of the skull, and the vessel appeared to be compressed by the edges of the fracture to an extent sufficient to prevent hemorrhage. It is reasonable to suppose that the depressed edge of the fracture recovered its position to some extent after the injury, partly from its own resiliency and partly from brain pressure, so that the hemorrhage which had apparently been free at first, was arrested by the pressure exerted on the bleeding vessel by the re-approximation of the edges of the fracture. The peculiarity of this case is, not the recovery of the child, for recovery is not so rare an occurrence, especially in children, after brain injuries with loss of brain substance; but what seems singular in the case is the fact that with the one exception of vomiting, the child never gave any indication of having received a severe injury of any kind, from the day of the accident up to the present time. She never betrayed the slightest want of intelligence from first to last, and a few minutes after the accident, as well as throughout her confinement to the room up stairs, readily recognized the voices of her associates who were playing on the street below. It seems to me the only reasonable explanation of the absence of brain symptoms, and one which is concurred in by Dr. Stewart, is that the extrusion of brain substance caused by the continued action of the violence which produced the injury, while relieving to some extent the brain pressure, by carrying with it the already severed artery, also saved the child from the immediate and remote effects of extravasated

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blood in brain tissue. I need scarcely say, that in the absence of symptoms, and of any spicula of bone which might irritate the brain; we did not interfere with either the fracture or scalp wound, but secured perfect quiet in a moderately darkened room, a position favorable for drainage, the continuous application of cold to the head for many days, regular action of the bowels, and the use of cold water dressing to the wound, which healed kindly in a short time; and after a few days it was with difficulty that the little patient could be restrained from playing with the other children when she heard their voices on the street, and for the last two or three months she has been playing about the streets, as lively as the best of them.—*H. Ross, M.D. in Canada Lancet.*

Abortive Treatment of Soft Sores.—Professor H. von Hebra advises as follows: After thoroughly cleaning the sore, it should be treated with a preparation of spirit and potash-soap, carefully dried, and pure salicylic acid applied to the sore, which must be covered up with plaster. The treatment succeeds best when this application is renewed for two days running, and the sore suppurates freely. After three days the sore is covered with a white scab. The salicylic acid should now be abandoned, and an emollient ointment spread on lint employed in its stead. The scab speedily separates, and the wound readily heals without any likelihood of a bubo forming.—*Wiener med. Presse*, 14, 1884. *Br. Pract.*

Treatment of Cancer of the Rectum.— In a clinical lecture at the Necker Hospital, Professor Trélat drew the following conclusions with regard to the treatment of cancer of the rectum:—(1) Cancers of the rectum should not be touched, unless they cause grave disorders. This rule should be positive, with the single exception that very small cancerous deposits may be removed from the lower part of the rectum and the margin of the anus. (2) In all other cases the treatment should be confined to complications and palliative operations. In giving these rules I am in accord with Prof. Verneuil. (3) As palliative operations, rectotomy may be done when the finger can be passed beyond the upper limit of the neoplasm. If the neoplasm is more extensive, the surgeon should abandon rectotomy, and work out a way of derivation; for by performing rectotomy in these cases, the surgeon is almost certain to injure the peritoneum. With the English surgeons, and Labbé and Tillaux, I am in favor of lumbar colotomy, because it is a simple operation, less dangerous, and affords a ready means of exit for the fæces. Other surgeons prefer to make an inguinal anus; but there is risk of opening the small intestine, with all the attendant dangers and inconveniences.—*Revue de Therap.*, May 15, 1884. *Br. Pract.*

The Treatment of Strangulated Hemorrhoids.—Dr. Monod, (*Med. Press*, Sept., '84) recommends forcible dilatation of the sphincter in stran-

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gulated hemorrhoids. This method, which Monod follows by dilatation with specula of various sizes, was long ago recommended by Verneuil in cases of simple piles, and it is claimed, was practiced by him with considerable success. Monod cites a case in illustration, which is a typical and severe case of strangulated hemorrhoids, in which an excellent result is obtained. With reference to the novelty of the operation, we take the liberty of stating that it is the same method practiced in a case of our own over a year ago. In this case the gentleman had been suffering for twenty-four hours, with excruciating pain and tenesmus, but no sphacelation had occurred. The anus was stretched to its utmost capacity by the fingers, — which are far preferable to any mechanical contrivance, — and the tumors reduced. A suppository of ½ grain of morphia was then given. The sudden and complete relief from pain, conjoined with a previously unknown idiosyncrasy, made the dose of morphia nearly a fatal one, for when called to see the patient three hours later, we found him in profound narcosis, the respirations being about six per minute, pupils contracted to a pin point, and coma profound. If was some hours before we breathed freely, and pronounced the patient out of danger. The piles were cured, as also was our skepticism regarding the efficacy of rectal medication.

A Case of Chancre of the Eyelid Produced by Inoculation.—In the *Philadelphia Polyclinic* for Nov. 15, 1884, Prof. Van Harlinger reports a case of unusual interest. A young man was struck under the eye during a drunken brawl. As a result, great swelling and ecchymosis of the lid and surrounding tissues occurred. To relieve the tension, the patient thrust a small penknife into the swollen lid. An officious boon companion thereupon insisted upon sucking out the blood from the injured part. The wound healed rapidly, and in a week was quite well. Two weeks later, however, a lump surmounted by a thin crust appeared upon the lid. This ulcerated at the site of the knife puncture, and began discharging a thin sero-purulent fluid. Upon examination the sore was found to be a typical chancre. There was enlargement of the preauricular and anterior cervical lymphatics. The patient had failed in health, and was complaining of dizziness, rheumatic pains and loss of appetite. The case subsequently fell into the hands of Prof. Ashurst, who states that a papular eruption had then appeared. The person from whom the disease was supposed to have been contracted was found, and a clear history of syphilis, with buccal mucous patches, was elicited.

Resection of Muscles in Infantile Paralysis.—Mr. Keetley has recently undertaken the resection of part of the quadriceps extensor femoris in a case of infantile paralysis causing inability to extend the right knee. By shortening the weak, relaxed, and partly atrophied muscle, the operator

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hoped to increase its strength, with the aid of electricity during recovery from the operation. Mr. Willet has already resected the tendo Achillis in paralytic talipes calcaneus, with good results, finding that the shortening of the abnormally elongated tendon enables the muscles of the calf to regain some portion of their lost functions, especially when the muscular wasting has been chiefly due to disease, and has not advanced too far. Mr.Keetley's patient was a boy aged six, who had suffered from paralysis of the right lower extremity for four years, and the muscular atrophy was not complete, yet sufficient to prevent thorough entension of the knee. A longitudinal incision was made in front of the thigh, about three inches in length, ending an inch above the patella; the skin was held apart by retractors, and one inch of the entire substance of the quadriceps was cut away with scissors, about two inches above the patella. The separated ends were united by means of about one dozen carbolised cat-gut-ligatures. Esmarch's bandage had been applied before operation, and only one small artery required ligature. The wound was dressed with a small iodoform-pad and carbolic gauze, and the limb placed on a back-splint at an angle of sixty degrees with the bed. The wound healed rapidly and perfectly, but as the operation was performed on May 5th, it is as yet too soon to determine the results as regards the function of the limb.—*Brit. Med. Jour.*, May 31, '84.—*Pract.*, Nov.,'84.

Antiseptic Incision in Hydrocele.—M. Juillard tries to demonstrate the superiority of an antiseptic incision, such as proposed by Volkmann, to injection of iodine. According to M. Juillard, the iodine injection, like all other methods of irritating the tunica vaginalis, is a simpler operation, but is followed by violent reaction. The cure is very slow, and there is generally a return of the disease. On the contrary, an incision carefully made, with every antiseptic precaution, never provokes inflammation due to reaction; it is not more painful than an injection, and cures as quickly, without relapse. The principal objection to this mode of treating hydrocele, is that it is long and requires great care and dexterity. M. Juillard's preference for treatment by incision is supported by fifty-four operations; he modified in some respects, the primary method of Volkmann. He maintains that anæsthesia is not necessary; there is pain only when the skin is incised, and that is done rapidly. Large incisions are preferable to small. An interesting detail in the operation, according to M. Juillard's modifications, is the resection of a certain portion of the tunica vaginalis, in such a way that suture of the edges of this membrane does not prevent the principal fold from being applied immediately against the testicular fold. M. Juillard considers this particular most important, the essential condition to attain obliteration of the tunica vaginalis by union of the serous walls, which prevents the return of the hydrocele. This suture,

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made with very fine catgut, is covered by the walls of the scrotum, also sutured. Volkmann places a drainage-tube in the tunica vaginalis; M. Juillard in the scrotal wall, and only for a short time. An antisceptic dressing is then applied. M. Juillard lays great stress on the application of sponges to the scrotum; they act as absorbent compresses. (*Revue de Chirurgie*, Feb. 10, 1884; *Med. Record.*) We are of the opinion that a cutting operation for hydrocele, is rarely if ever necessary, as the treatment by carbolic acid injection, leaves nothing to be desired. It is safe, and apparently certain. We have yet to learn of a recurrence following it.

Obstetrics and Gynecology.

Edited by E. P. MURDOCK, M.D., 130 S. Halsted St.

Gynecological Clinic; held by E. P. Murdock, A.M., M.D, College of Physicians and Surgeons, Chicago. Reported by Geo. S. Harkness, M.D. — GENTLEMEN — This patient, Mrs. Lizzie K., is twenty-five years of age; has been married three years, and has one child sixteen months old. She menstruated first at thirteen, and always had reasonably good health until after marriage. You will notice that she is considerably under size, weighing only about ninety pounds, childish in manners, but with features withered and prematurely old. She says that she was very sick during the entire period of her gestation, first with persistent nausea and acidity of the stomach, later with neuralgia, and finally with persistent toothache—and this is the particular phase of the case, to which I desire to call your attention.

Neuralgia, toothache, and decayed and crumbling teeth, are very common complaints of pregnancy; and we are daily informed by women, that they began to lose their teeth during the time of carrying their first or second child. This is a very natural sequence of the conditions of the system at such time, and, if properly managed, much suffering can be forestalled and prevented. In the first place, the system of the mother is called upon for extra supplies,—to build up a new being,—and these supplies must be, to a great extent, solid matter and of an alkaline nature, calcic phosphate for the osseous system, and the alkalies found in the blood, and other fluids and soft structures of the body. At the same time, the powers of nutrition in the woman are very greatly diminished by the reflex disturbances from the enlarging uterus, so that while the demand has increased, the supply has become diminished. But the fœtus continues to grow, and this growth must be at the expense of the entire anatomy, at a time when there exists violent disturbance in the physiology of the woman. From this persistent system of robbery her bones become

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fragile and subject to fracture, and her entire health is undermined. But the teeth suffer from two forces, first, demand upon the system for calcic phosphate, and second, acid eructations from the stomach. These can both be largely counteracted by the very rational administration of that which the system most needs,—calcic phosphates. Hence I am in the habit of prescribing twenty grain doses, three to five times daily, of precipitated phosphate of lime, to be taken *ad libitum*, and associating it with a grain diet, oat-meal, cracked wheat, etc., all of which, as a rule, is quite palatable and agreeable to the patient. It is not an uncommon practice, especially in cities, for the physician to ignore these complaints, or to refer them to a dentist, by whom the teeth are extracted and the sequence is more direful than either physician or patient could have imagined. Indeed, the next patient, whom I shall present to you, consulted a dentist fourteen years ago, at her fifth month in pregnancy, and he extracted thirteen teeth. Five days afterward she had a miscarriage, was in bed nine weeks, and has never yet regained her health,—or her teeth,—and yet I am credibly informed that that dentist still lives.

And here I wish to reaffirm what some of you have heard me say before, that the pregnant woman should be considered *a patient*, from the earliest months of gestation until final recovery from the violence of the parturient act, when the uterus has completed the process of involution; and that during this entire period of twelve months or more she should be under the careful observation of her family physician.

Extra Uterine Pregnancy.—Dr. D. C. Cocks, of New York, adds another case of this dreaded calamity, successfully treated by electricity. Dr. Allen's success in destroying the fœtus in tubal pregnancy in 1869 and 1871, drew the attention of the profession in that direction for a time, but little was added to the efforts in that direction, until the appearance of Dr. Rockwell's paper last year, followed by the successful treatment of a very critical case, by Dr. Paul F. Munde. The extremely delicate condition of Dr. Munde's patient, the shock produced by examination leaving the patient in a condition bordering on collapse for twenty-four hours, demonstrated the safety of the remedy, even in cases of extreme prostration, and this followed by Dr. Cocks' case places the use of electricity in the category of safe as well as sure remedies for extra uterine pregnancy, and gives the physician means of doing something for his patient, when Tait's operation would not be entertained either by the patient or her friends. The fact that the electrodes can be applied efficiently to the mass will entirely supersede the electro-puncture.

Extraction of Hair Pins from the Rectum and Uterus.—Dr. W. R. Adamson, of N. Y., relates a case where a woman had introduced a hair-pin into the uterus to produce abortion; also a case of a young girl intro-

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ducing one into her rectum; in both cases the points of this biped instrument were downward. A silver catheter was introduced to cover one point while the other point was seized with forceps and extracted. The suggestion is worth remembering, as the writer once had a very perplexing experience in effecting a forcep delivery of this same kind of foreign substance from a female bladder.

Use of Nitric Acid in the Uterine Cavity.—Dr. Thomas Moore Madden, of Dublin, with so long a list of initials after his name that we wonder if he can "read his titles clear" with much precision, says that the use of nitric acid to the *interior of the uterus* is of such importance that he takes great care to give due credit to its author "Dr. Kidd" and explains the use of certain ingeniously constructed forceps so essential to the proper and careful application of this powerful escarotic. This is certainly *heroic* to say the least of it. Per contra, Dr. Emmet, one of the foremost and most progressive gynecologists of the day, says in his late work, "It is believed that in time professional opinion can be influenced to *abandon* intra-uterine medications as one not based upon sound views of pathology. There certainly is some lack of harmony in the teaching of these gentlemen; "when doctors disagree who shall decide?"

Pediatrics.

Edited by MARCUS P. HATFIELD, M.D., 3446 Wabash Ave.

A Case of Ephemeral High Temperature in a Child.—A temperature of 105 degrees, or a fraction above, is by no means unusual just before crisis in pneumonia, or in scarlatina, with children; but the following case is remarkable from the absence of all apparent cause for the remarkable elevation of temperature and the type of child in which it was found. E. P., the subject, was not one of those nervous, impressionable children whom we expect to find quickly responding to every source of irritation, but on the contrary was phlegmatic, passive, and so dull as to be considered hardly up to the average of the other children in the hospital. In fact she was sent to us as a confirmed masturbator, which was supposed to account for her heaviness and listlessness, although this probably has no bearing on the etiology of the case. Its clinical record is as follows: E. P., age, 9; nationality, American; admitted to hospital Dec. 25th, 1884. Frequent vomiting. Tongue was furred, flabby and reddened at the borders. Face much flushed and skin hot and dry. Breathing bronchial, temperature 102.5 degrees, pulse 128, respiration 34 to the minute. Patient complained of pain in the epigastric region. The liver was found considerably enlarged and tender and therefore a brisk calomel

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purge was administered and a sinapism applied over the epigastrium.

Dec. 26th.—Temperature 106.2-5 degrees, pulse 148, respiration 36. Bronchial breathing well marked over the right lung, but both congested. Liver still enlarged, and bowels much constipated. Senna and ergot. At 3 o'clock p.m. the same date, temperature was 101.5 degrees. Bowels had not yet moved, though cathartics had been administered.—℞ Sal. Rochelle q.s. At 6 o'clock p.m. of same date, temperature was 99.5 degrees, pulse 126, and respiration 30. Cough frequent and expulsive in character. Breathing still roughened, but no rales. Liver has not diminished in size.

Dec. 27th.—Temperature 99 degrees, pulse 114, respiration 24 per minute. Breathing slightly rougher than normal over right lung. Bowels moved slightly by an enema. Liver markedly diminished in size.—℞ Muriate ammonia cough mixture.

Dec. 28th.—Temperature 99.3-5 degrees, pulse 124, respiration 30. Herpes labialis. Breathing in right lung again roughened. Bowels perversely constipated. Pulse irregular, small and difficult to count. Coughing some.

Dec. 29th.—Temperature 99.1-5 degrees, pulse 120, respiration 30. Herpes on left ear and nape of neck. Breathing about normal. Liver normal. Coughing yet. Constipation not improved. Gave compound liquorice powder.

Dec. 30th.—Temperature normal. Bowels moved freely. Child was playing about the ward.

The herpetic eruption gradually dried up, and case discharged January 9th, returning to school, none the worse for her curious experience.

Remarks—This case is unique in its sudden elevation of temperature, which is higher than any previously noted in our hospital records; 101 and 102 degrees are found in the majority of cases of simple ephemeral fever; 103 and 104 degrees occasionally found with "foul bowels" and preceding the exanthemata, while a temperature of 105 degrees had been met with only in pneumonia, or scarlatina, of a grave type, but here is a temperature of nearly a degree and a half higher without serious import. On the morning of the 26th it apparently bid fair to become a case of the gravest prognosis, but in six hours the storm had passed its height and the case went steadily on to recovery without a set back. What its exact etiology is we can only surmise. Had the fall in temperature coincided with prompt catharsis we might have attributed the pyrexia to gastro-intestinal irritation, but as a matter of fact the bowels did not move until twenty four hours later. Physical examination at first designated the liver as the erring member, but later the right lung was apparently not far from pneumonia, or had we only to do with a case of toxæmia due to

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a temporary failure on the part of the liver to properly perform its functions? Who can report an analogous case with a clinical chart similar to the annexed:

DATE.	TEMP.	PULSE.	RESP.
xxv—a.m.	102.5	128	34
xxvi—a.m.	106.2-5	148	36
xxvi—p.m.	99.5	126	30
xxvii—a.m.	99	114	20

Caseous Glands.—Dr. Geo. R. Fowler, in a recent number of the New York *Medical Journal*, strongly recommends the early removal of caseated lymphatics on the ground:

1st—That these cheesy glands are not innocent, but are reservoirs of the special poison containing tubercle.

2nd—These cheesy foci are rapidly propagated and constitute the so-called caseous lymphadenetis, preceding tuberculosis.

3rd—There is often a period of quiesence, during which there is no apparent advance, but during which the patient is continually in danger of an outbreak of general tuberculoses.

4th—Consequently, wherever practicable, early, thorough and complete removal of these glands should be practiced, even in doubtful cases of persistent adenitis without caseation.

—Quebracho, in ten drop doses, according to the North Carolina *Medical Journal*, has been used with gratifying results in a case of dyspnœa, due to laryngeal diphtheria. The dose was repeated every half hour and produced unexpected vomiting and relief without weakening the heart's action. Similar results were obtained in two subsequent returns of the paroxysms, and a further trial of the drug in similar cases is desirable.

Books.

COMPARATIVE PHYSIOLOGY AND PSYCHOLOGY.—By S. V. Clevenger, M.D. Chicago: Jansen, McClurg & Co.

In this interesting little volume Dr. Clevenger has most manfully and scientifically grappled with the physio-chemical basis of psychological phenomena. This has been a field of most furious warfare between orthodoxy and evolutionism, mainly because of the extensive inroads that scientific pioneers have of late years made upon the defenses of bigotry and superstition with which certain intolerant theologians have fortified their position. We can but admire the tact displayed by Dr. Clevenger, in avoiding any attempts to coerce the views of such as are not open to conviction, who, if convinced at all, would be so against their wills, a re-

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sult not very enduring, as a rule. "That mind is allied to chemical affinity as a property of matter seems blasphemous to those of the old superstitious way of thinking. To such, who cannot rid themselves of their fetiches, and whose bias prevents their intelligent examination of any physiological study I have nothing to say." In this short space the doctor relieves himself of much thankless and profitless labor. It seems absurd to us, that anyone of intellectual pretensions should seek for other than a physical explanation of psychological phenomena. Mind is but a form of force, and is the result of molecular energy, being really the corelative of muscular energy. Both are vital properties of forms of organized matter, and their difference lies mainly in the differentiation of the two forms of tissue; the varying complexity of their molecules. Vitality or life force is the manifestation of molecular energy of living cells; in the case of the muscle, its result is muscular force, potential or dynamic; in the lower centers of the brain it is nervous energy or impulse which exercises a controlling influence upon the tissues of less complexity of organization; in the cerebral cortex it is mind. There is one point set forth by Dr. Clevenger, to which we must dissent, viz., that there is no "unknowable," and that the debatable ground is the "unknown." In denying the existence of Spencer's "great unknowable," we are too nearly approximating our orthodox friends, who already, as we interpret them, know it all,—from a spiritual standpoint,—and who have a ready explanation (?) for all dubitable points. We must all acknowledge a limit to scientific research, and evidence evolutionary piety by our awe of that which must ever remain a terra incognita for the scientist, and for the explanation of which no hypothesis will suffice. It matters not what name we may apply to the "unknowable," we are religious by our mere recognition of, and respect for, its existence. Dr. Talmage would probably dissent from this, for to him, "evolutionism" and "atheism" are synonymous. We are struck by the prominence which Dr. Clevenger accords to protoplasm, the more especially as we hold the belief that a more careful study of protoplasm as an entity would demonstrate in miniature many of the apparently inexplicable problems of life. As the Doctor states, "the simple nature of protoplasm has by no means been proven." Surely a substance which has in a minor degree all the properties of complex animal life, deserves more attention than is usually given it. As we understand the author, he endeavors to illustrate the possibilities inherent to molecular and chemical energy by directing attention to the apparent volition which is exercised by the amaeba in the peformance of its various functions. The rejection of inert matter on the one hand, and the assimilation of nutritive material upon the other, are especially noted as an evidence of the wonderful results of chemical affinity. For our own part, we are quite ready to

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believe that this phenomenon is the first step in the ascent to that which we term "mind." Call it an "instinctive selection" if we will, it is still a forecast of mind. We are sorry that Dr. Clevenger has avoided the issue of spontaneous generation, the more especially as he is liable to be misunderstood. Does he mean a spontaneous development of a special organism, or the spontaneous development of vitality as a result of differentiation of matter? Spontaneous generation, as ordinarily understood, we are loth to accept, but that at one time, certain circumstances of environment resulted in the development of vitality in matter previously inert, we firmly believe. That such development is not capable of demonstration at the present day, is no argument, any more than is the same objection to other evolutionary theories. A peculiar fact developed by Dr. Clevenger, is the co-relation which exists between the senses of hunger and sexual desire and chemical affinity. Starting with chemical affinity we arrive in the process of differentiation at sexual attraction. The ingenuity of our author is displayed in his assertion that all ungratified desire is painful, and his illustration of excretory pain in the pangs of parturition. The infant as an excretion is a new phase of physiology, but the doctor's position in this respect is unassailable. Clevenger's views of the bearing of the arrangement of the valves of the human venous system upon evolutionary doctrines are well known, and we will merely say that we consider them second in importance to but one fact, viz., the transmissibility of syphilis to the monkey, as shown by Martineau, to which we believe we were first to call attention as an evidence of evolution. A bone is thrown to the gynæcologist, by Clevenger, in the suggestion that it is the assumption of the upright position in the process of evolution, that has predisposed the human female to prolapsus uteri, etc. We wish that several of our own patients could play the role of Nebuchadnezzar long enough to return the missing link to its original plane. The theory is perfectly logical in spite of the insult to our friends who make taut the main brace by shortening the round ligaments. The obstetrician comes in for his share of evolutionary evils in the changes which the assumption of the upright posture has wrought in the pelvis of the human female. The ophthalmologist is reminded of his abject dependence upon evolution, in the assertion that the lachrymal secretion is the result of the necessity of an eye primarily amphibian, accommodating itself to its new environment by providing itself with a lubricant approximating in its characters the original habitat of the animal. This renders the mermaid not so mythical after all. The closing chapters of Dr. Clevenger's work are devoted to a specious consideration of the various faculties of the mind, which are very logically and critically analyzed and interpreted. We were much amused

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with the illustration of disgust associated with an irritable stomach, in which a visitor to a hotel deposited his recently devoured breakfast upon the hotel register upon observing therein the autograph of Oscar Wilde. Why this phenomenon, which is neither psychological nor physiological, should crop out in a scientific work, we cannot understand, as we thought we were well rid of him. But he "will not down." We are pleased to note that Dr. Clevenger has at last been aroused by the piratical plagarism of his original work by some of our eastern brethren. As he intimates, the star of intellectual progress does not shine in the East alone. Taking the work as a whole, we have seldom perused a work of such rare interest as the "Comparative Psychology and Physiology," and we are certain that between its covers lies a wealth of information that can be found in no other work of our acquaintance. The amount of labor which it represents is simply stupendous. G. F. L.

A HANDBOOK OF SKIN DISEASES: By Arthur VanHarlingen, M.D., Professor of Diseases of the Skin, in the Philadelphia Polyclinic and College for Graduates in Medicine, etc.

This is a neat little work of about 300 pages, designed principally for the use of the student. While all known forms of skin disease receive due consideration, it refers principally to the description, diagnosis and treatment of the commoner and more distressing forms; which, in this respect, are treated upon at full length, with the latest and most approved views relative thereto, thereby rendering it an excellent work for the general practitioner. With a view to ready reference, the alphabetical order of arrangement has been adopted. The recognized merit of Dr. Van Harlingen as a writer and dermatologist is alone sufficient to guarantee the excellence of the work. H. J. R.

THE VISCERAL NEUROSES; being the Gulstonian Lectures on Neuralgia of the Stomach and Allied Disorders, delivered at the Royal College of Physicians, in March, 1884, by T. Clifford Allbutt, M.A., M.D., etc.

This little book, an octavo of one hundred pages, calls attention to a group of disorders that are very generally either overlooked, ignored, or misunderstood, by practitioners. The author discusses the subject with originality and ability, but the valuable lesson he teaches is almost hidden by a mass of irrelevant though elegant verbosity. Pruned of this verbosity the work would make a valuable contribution of five or six pages to a medical periodical.

A MANUAL OF THE MEDICAL BOTANY OF NORTH AMERICA. By Laurence Johnson, A.M., M.D., Lecturer on Medical Botany, Medical Department of the University of the City of New York.

Among the series of books in Wood's Library of Standard Medical Authors, for 1884, the above work is to be found. An important desideratum, long since felt in this line of medical literature, has been satisfactorily filled by Dr. Laurence Johnson's book. Through it the student, with but a small amount of application, can obtain a knowledge of the chief representatives of the North American Medical Flora, and also of some specimens adopted by our soil. The efforts of Dr. Johnson deserve a liberal support on the part of the profession.

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Journal de L'Anatomie et de La Physiologie Normales et Pathologiques De L'Homme et Des Animaux.—Publié par MM. Charles Robin, Professeur à la Faculté de médecine de Paris, et G. Pouchet, Professeur au Muséum d'histoire naturelle de Paris. 21e Année (1885.)

Ce journal paraît tous les deux mois et contient: 1 Des *travaux originaux* sur les divers sujets que comporte son titre; 2 l'*analyse* et l'*appréciation* des travaux présentés aux Sociétés francaises et étrangères; 3 une *revue* des publications qui se font à l'étranger sur la plupart des sujets qu'embrasse le titre de ce recueil.

Il a en outre pour objet; la *tératologie*, la *chimie organique*, l'*hygiène*, la *toxicologie* et la *médecine légale* dans leurs rapports avec l'anatomie et la physiologie;

Les application de l'anatomie et de la physiologie à la *pratique de la médecine, de la chirurgie et de l'obstetrique.*

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Editor Western Medical Reporter—DEAR DOCTOR:—Permit me to call the attention of the profession to one of the most useful, ingenious and complete modes of treating many diseases of the "womb" that it has been my good fortune to try. I allude to "Dr. Anderson's Antiseptic Carbolized Capsule," with absorptive filling. By the use of this capsule the physician is saved the nauseating performance of introducing caustics or other applications by cotton, forceps, sound, etc. All that is necessary, is to introduce your medicament on absorbent cotton in the capsule, close it and then introduce it, and the work of application is done. By means of a string there is no trouble in removing the cotton [see illustration among the advertising pages]. Owing to the softness and easy pressure, the patient feels no inconvenience whatever. As a pessary, I regard it the best I have ever seen. As a "rectal capsule" I have not had the opportunity of testing it, but predict a success. The first case in which I had occasion to use the capsule was with a lady 36 years of age, with extensive ulceration of the os uteri. She informed me that she had been under the treatment of various physicians for three years, but could not see that she had improved. In addition to the ulceration, was antiversion, discharge free and very offensive, so much so that she dreaded society. The terrible drain upon her was wrecking her system. About the middle of last November I commenced treating her by means of "Dr. Anderson's Carbolized Capsule." For the first ten days the discharge was so great, that the capsule was changed twice in twenty-four hours; as she improved, it lessened rapidly and a change once in forty-eight hours was sufficient. By the first of January she had gained eight pounds. At the present writing no ulcers have appeared.

The benefits derived from its use as a pessary, certainly commands the intelligence of physicians. I have also used the capsule in several cases of leucorrhea with better success than any other mode I have tried. While I am not quick to run after strange gods, yet I candidly believe the physician who will give this capsule an impartial trial, will agree with me, that it is the easiest and best means of treatment known, as the medicine prescribed comes in contact at once with the diseased parts and is retained there until it is absorbed.

Hamilton, O., February 20, 1884. Yours truly, JOHN R. BROWN, M.D.

SUGGESTIONS IN REGARD TO THE USE OF MINERAL EARTH IN SENILE GANGRENE.—In this painful disease of old people the *Earth* dressing is employed with advantage after the following method: The Earth-paste made with water thoroughly kneaded, in layers from ¼ to ½ inch in thickness is kept constantly applied to the necrotic and adjacent healthy tissues, the whole member being encased in the *Earth* poultice, which in turn is covered with cheese cloth, absorbent cotton and bandages.

The dressing is changed as often as twice in twenty-four hours. The advantage of the *Earth* is shown by the soothing effect on the pain, by the good influence it exercises in limiting the amount of destruction of tissue by gangrene, and also by its hiding from view an offensive and disagreeable member. With a limb encased in the manner suggested the patient is made more comfortable, and is enabled to use the diseased member to better advantage. Prepared by the National Pharmacy Association, Baltimore, Md., U. S. A.

DISEASES OF THE URIC ACID DIATHESIS.—By Wm. B. Gray, M.D., Richmond, Va., Academy of Medicine. * * * "The careful record of these many cases shows that when the urine is of high specific gravity by reason of the presence of an abnormal amount of uric acid, Lambert's Lithiated Hydrangea, in my hands, has never failed to be of signal benefit. In cases in which the specific gravity exceeds 1015, it invariably gives good results.

"Guided by these indications, I have successfully used this preparation for nearly a year in the various diseases produced by the well-known irritating properties of uric acid, finding that it acts like a charm in cystitis, excessive micturation, headaches, etc. I have also used it with satisfactory effect in many cases of gastric and abdominal dyspepsia, diabetes, Bright's disease, and rheumatism (particularly muscular). In fact, in all cases where uric acid is to be combatted Lambert's Lithiated Hydrangea will be found a potent remedy. I would not be without it. I generally give one drachm doses four times a day."

DR. W. J. SCOTT, professor of the Principles and Practice of Medicine, Medical Department of Wooster University, Cleveland, Ohio, says: "I have prescribed Bromidia, and believe the remedy *reliable;* regard the combination *as a valuable one.*"

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EVERY mother knows that the greatest care is necessary during the first three years of a child's life, and the most dangerous mistake made in the care of infants is that of using the wrong kind of food. All starch foods are very injurious. Dr. Abraham Jacobi, President New York Medical Society, says: "Horlick's Food for Infants is deserving of more favorable mention than others, as it is a food in which the starch has been converted into dextrine and grape sugar, and is therefore more easily digested." Book on treatment of children sent free. Horlick's Food Co., Racine, Wis.

AT a meeting of the Union District Medical Society (counties in Ohio and Indiana), held at Oxford, Ohio, Oct. 25, 1883, the Society adopted and ordered published the following: "*Resolved*, That after carefully inspecting the facilities of the Oxford Retreat, and from a knowledge of the eminent abilities of its Superintendent, we hereby endorse it as an institution in every way adapted to the care and treatment of the cases for which it was designed, and commend it to professional support."

DR. RICHARD MCSHERRY, Professor Practice of Medicine, Baltimore University, says: "I have used the preparation known as Iodia, prepared by Messrs. Battle & Co., of St. Louis, in my practice, and have found it a very satisfactory agent in cases for which it is deemed most appropriate."

OFFICE OF C. F. BRANCH, M.D.,
Sec'y of Board of U. S. Examining Surgeons,
COVENTRY, Vt., Jan. 7, 1884.

J. A. MCARTHUR, M.D.: Having used your valuable combination of Hypophosphite of Lime and Soda for more than a year, I would like to report to you one case in particular, and then ask a question.

In June last I was called to see a young man aged 18, whose mother and one brother had died of phthisis. I found him suffering from severe pleuretic pain, night sweats, severe, distressing cough and profuse expectoration, characteristic of first stage in phthisis. Tongue coated, pulse 128 to 130, temperature 104 deg. at night. Profuse crepitus in lower half of left lung, dullness on percussion over almost entire left side. Intercostal depression marked on left mammary, extending backward into left axilary region. No appetite, and general facial expression of rapid emaciation, etc. I began the use of your Syrup Hypophos. Comp., and continued it four months, using some other means for night sweats and such other conditions as seemed to require special attention. To-day the young man is about the farm doing light work. Appetite excellent; no cough; no night sweats; the wasting of lung substance is arrested, leaving dullness in left lower lung; vesicular murmur gone. The disease is arrested at least, and he has increased in weight 43 pounds.

I have used the Syrup in five other cases during 1883, with most gratifying results.

THE use of prepared food for invalids and young children has become a recognized necessity the world over. The preparation which most closely resembles mother's milk is confessedly the best food for nursing babes, and the preparation which is most grateful and nourishing to the delicate organism of the invalid or convalescent is destined to win the favor and confidence of the medical profession. Mellin's Food has long since been found to meet these requirements.

"I WISH to give my testimony to the value of Dr. McArthur's *Syrup of Hypophosphites*. I have used it, and am *now* giving it in what I call a typical case of phthisis with a most excellent result. The patient (a young lady belonging to a phthisical family) has improved in every way, has gained in flesh and strength, cough much less severe, night-sweats gone, catamenia returned, etc. I had previously, and for months, used every remedy I could devise without any benefit. She is now taking the fourth bottle. I believe the value of the Syrup cannot be over-rated, as it supplies the elements of nerve nutrition in an easily assimilable form."

L. F. WARNER, M.D.,
Hotel Pelham, Boston, Mass., Dec. 19.

Referring to the above, Dr. McArthur begs to say that at the last meeting of the Massachusetts State Medical Society, Dr. Warner was kind enough to state to the writer, and also to a group of Fellows of the Society who were present, that he wished to confirm all that he had previously said in favor of *McArthur's Syrup*, and desired to add that he constantly used it in his practice, as he had found it a valuable remedy in many uterine affections.

DECIDED superiority is claimed for the Anglo-Swiss Milk Food in comparison with any other farinaceous Food for infants. No so-called Milk Food consists entirely of milk; all are partly composed of cereal products, involving, when not properly prepared, the presence of an injurious amount of starch, which the highest authorities agree in condemning for young children. The Anglo-Swiss Condensed Milk Company overcomes this objectionable feature of Milk Food as usually supplied, by meeting an essential requirement in the method of preparing it, so that when gradually heated with water, according to the directions for use, the starch contained in the materials used is converted, in a satisfactory degree, into soluble and easily digestible dextrine and sugar.

The Anglo-Swiss Milk Food has been found to meet these essential conditions to the satisfaction of physicians and others who have taken the pains to examine it, and we invite critical examination of it in comparison with any other Food.

H. A. COTTELL, M.D., Demonstrator of Anatomy, Microscopy and Medical Chemistry, University of Louisville, Medical Department. Celerina is a combination of drugs, which meets all the requirements of a first-class prescription; it is efficient, agreeable and safe. I have used it in two cases of neurasthenia, with highly satisfactory results, and shall give it still further trial.

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THE WESTERN
MEDICAL REPORTER

VOL. VII. CHICAGO, MARCH, 1885. NO. 3.

Medicine.

Edited by WM. E. QUINE, M.D., 3151 Wabash Ave.

Death from Peritoneal Bands and Adhesions Obstructing the Ileum.— In presenting this case to the profession I omit all details of history and treatment, as they are not essential. A general description for the purpose of illustrating the manner of death will suffice. Mr. D. P., a man of 30 years, married, of good habits, and apparent good health was attacked very suddenly in the evening of March 14, 1884, with severe pain in the abdomen, opposite the umbilicus. It lasted for five or six hours and then subsided, as we supposed from the effect of the remedies used. But in spite of the treatment it recurred again after a few hours' rest and again subsided, and this condition of things continued with same changes as to severity and frequency until death four weeks later. Soon after the attack he began vomiting. At first it was very distressing but it soon became passive and continued with some changes from day to day until the end. At times he vomited simply what he swallowed and at others, especially during the first two weeks, stercoraceous matter. During the first three weeks the temperature did not exceed 100° and most of the time it was about normal. His pulse during that time ranged between 75 and 85 per minute, growing gradually weaker. The last days they were very rapid and scarcely perceptible at the wrist. There was no tympanitis and but very little tenderness on pressure and at times the abdomen was quite flat and had a doughy feel. During the paroxysms of pain the abdomen would become as hard as a contracting uterus in labor, although there was no muscular rigidity or increase of tenderness, and during the intermissions a little gentle kneading of the abdomen would reproduce the tense condition without producing pain. This was most marked dur-

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ing the last week of the disease, at which time the patient was much exhausted, had a husky voice, lead-colored skin, and a general pinched and emaciated appearance. The pains had lost their severe character, producing rather a sense of suffocation, with general numbness, and as he described it, felt as though his stomach was being crowded up under his ribs. Through the entire sickness, except one day, there was not a voluntary passage from the bowels, although before the attack his bowels were very regular. But by the aid of injections and laxatives he succeeded in having a few little elongated lumps of fæcal matter, never exceeding $\frac{3}{8}$ of an inch in diameter, pass his bowels every day or two, and at the end of the third week he had a slight diarrhœa for one day. Even in the absence of pain through the entire time he was restless and tired and slept but very little, never to exceed an hour at a time. Treatment in this case was of little avail. Opium and chloroform were the principal medicines used. They retarded vomiting and pain, but controlled neither. Many other medicines were tried, and the case was treated from every possible standpoint of theory, except surgical operation, and there seemed to be no time when that was admissible. Rectal alimentation gave good evidence of its utility in this case.

Drs. J. D. Skeer and C. W. Earle were called in council and agreed with me in my early diagnosis of mechanical obstruction of the small intestine, probably at the ileo-cæcal junction, but of what character an opinion was not ventured. A favorable prognosis, however, was not entertained. He died on the 28th day, and the autopsy revealed many peritoneal adhesions and bands of long standing and very firm, tying and binding the convolutions of the ileum down into the pelvic cavity. One of these constricting bands was firmly attached to the anterior abdominal wall half way between the umbilicus and the middle of Poupart's ligament on the right side. At its attachment it was about one-fourth of an inch thick and three-fourths of an inch wide. It then spread downwards to the left side of the the pelvic cavity where it was firmly adherent from the brim far down upon the inner wall, becoming fasciculated and embracing the folds of the ileum between the fasciculi, furnishing a band that held the larger mass of the small intestines in the pelvic cavity. It was necessary to divide these bands in several places on the pelvic wall before the intestines could be lifted out of the pelvic cavity, and when lifted out they were all tied together by old bands of peritoneal adhesions which did not present the slightest evidence of recent inflammation. But the intestine was inflamed and very much softened for a distance of about four feet, which came down to within twelve or fourteen inches of the ileo-caecal junction. There was no evidence of previously existing disease of the intestine. It

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was uniform in thickness although its caliber was contracted, the smallest place being about three-eighths of an inch in diameter. The intestines were so glued together by their sides and bound down by cross bands that peristallic action must have ceased long before. Nature can accommodate herself to many unnatural conditions, but it is remarkable that in this case the functions were performed so long and so well. Eight years ago I treated this patient for typhoid fever which was moderately severe, run an even course, and made a good recovery. (?) The most marked and interesting thing about the case, as it now appears, is that at that time he had a moderate amount of peritonitis which in all probability gave rise to the adhesions which subsequently and unquestionably caused his death.—*A. E. Hoadley, M.D., Prof. Anatomy, Col. P. & S., Chicago.*

Diurnal Variations in Weight.—Pastor Malling-Hansen, the director of the Royal Deaf and Dumb Asylum in Copenhagen, has published an interesting pamphlet on the "Periodicity of the Weight of Children." He found that body weight varies from day to day,—a variation of two pounds occurring sometimes during a period of twelve hours. Eating exerts greater influence in causing such fluctuation than exercise, occupation, or bathing. The increase in weight associated with growth does not go on regularly. There is stoppage of increase between the beginning of May and July, during which time there may be a loss exceeding double the average ultimate gain. During August, September, and October, there is steady increase in weight, sometimes rising to five times the average increase. During the remainder of the year there are slight deviations in both directions from the average rate of increase. The actual gain in weight seems to occur during the fifth part of the year, while the remaining time is occupied with loss and its replacement. There is correspondence between vacillations in weight and in temperature; increase and decrease of body weight and heat go together, hand in hand. A year that has had most changes in temperature is most unfavorable to nominal increase in weight. The investigations are considered so novel and valuable that the Danish government, and the "Carlsbergfond," have granted sums of money to promote their continuance and extension.

Cheap Advertisement.—The inventive genius of an enterprising editor of a certain medical journal has spread to the four winds the fabricated piece of news that Dr. H. V. Sweringen, of Fort Wayne, Ind., has been called to the chair of Materia Medica and Therapeutics in the College of Physicians and Surgeons of Chicago. If the editor of this paper relies upon his imagination for all the items in his journal, it were better to name it more in harmony with its utility. We suggest the name of ***Medical Puck.***

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Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

Alcoholic Paralysis.—Magnus Huss was the first to mention the existence of paralysis in chronic alcoholism. Later, M. Lancereaux attempted the first description of this paralysis, and dwelled upon the fact, that akin to saturnism, it invades in preference the extensor muscles of the limbs. In 1867, Lendet, of Rowen, mentioned the painful character of this affection particularly, which at night affects the lower limbs. Anatomically, Leudet produced a very important fact: the integrity of the spinal cord and the lesions of the peripheral nerves and muscles wherein the altered branches are distributed. These lesions have been found by M. Lancereaux. In 1872, Drs. Wilkes and Lockart-Clarke, for the first time, drew the attention of the profession to a paralysis, observed, they say, quite frequently in London, in women, even in the higher walks of life, which they accorded to designate, alcoholic paraplegia.

We lack in premonitory phenomena, for in the first periods of this disease it is difficult to obtain an acknowledgment of the facts, and after it is fully developed, the mental faculties are found peculiarly affected.

It seems that the variety of alcohol has no special influence in the production of these disturbances; but in the majority of cases, the female and not the male toper, is affected. Neuropathic antecedents may aid in this proportion. The initiation of the disease is frequently the same. Aside from the nocturnal reveries, nightmares and horrid visions, one of the first signs of this paralysis appears to be the manifestation of acute pains, chiefly in the legs. These pains resemble, at times, those of the first stage of locomotor ataxia; they are tingling, formicating, shooting, veritable lightning-like pains, that affect the limbs, principally at night. These pains soon become general, occupy, symmetrically, the legs at first, and are accompanied by cutaneous hyperesthesia; in turn they invade the arms, and are followed, at the end of a certain time, by analgesia. Then motor-paralysis ensues; this is also symmetrical, and affects, in preference, the extensor muscles. When sitting on a high chair, the feet of those affected by this disease hang down inert, extended, almost on the same level with the legs. The legs are, besides, affected by vaso-motor disturbances; diffused redness or livid color, œdema of the ankles, without sugar in the urine and local sweats of the feet and hands, which appear and disappear suddenly. After a time, fibrous adhesions of the tendons and inspissation of the connective tissue of the feet occur, which render their action more or less permanently impaired. The paralyzed muscles are soft, and their electric excitability diminished. The patients always

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deny their habits, like the opium eaters, and our information is obtained, almost wholly, in an indirect manner through the surroundings.

The form of this paralysis is essentially chronic, rarely acute as in the case cited by Moadbent. It is progressive and fatal, if intemperance is persisted in, or if the intoxication is of long standing.

The differential diagnosis must exclude locomotor ataxia, with which it has in common the pains, in early date; diabetes, which causes pains of the same character, and saturnism, which is equally manifested by paralysis of the extensors.

The treatment is essentially hygienical; suppression of the alcohol habit, hydrotherapia; tonic regimen. Relapses are frequent.—*Dr. Charcot in Journal des Connaissances Médicales*, Oct. 28, 1884.

Diphtheria Treatment by Resorcin.—Dr. Leblond communicates to the *Societé de Medicine de Paris* his experience on the employment of resorcin in the treatment of diphtheria, with the following cases:

1. A syphilitic girl, aged 17, patient at St. Lazare, is taken sick with tonsillar diphtheria and swelling of the glands, Nov. 23, 1882. Topic applications, by means of a camel-hair brush, with resorcin solution in glycerine, one in fifteen, and chlorate of potassium internally. On the following day, the tonsillar diphtheritic patches have decreased in thickness, but they have invaded the velum palati. Nov. 26, pseudo-membranes and ganglionary tumefaction have both disappeared.

2. A child 4 years of age; tonsillar diphtheria and glandular swelling. Topic applications of resorcin solution as above, and chlorate of potassium internally. The pseudo-membranes become thinner the following day and disappear entirely at the fourth day, as well as the glandular swelling.

3. A child taken with the croup, under Dr. Delthil's treatment (fumigations of coal-tar and turpentine). Tracheotomy, April 12, 1884. April 25, the tracheal incision is covered by diphtheritic membranes. Same topic treatment as in previous cases. April 26, pseudo-membranes dry up and fall off the following day. Ten days after the operation, patient succumbs to a syncope, when all the local symptoms of diphtheria had vanished away.

4. The child's sister, æt 18, is taken with diphtheria May 1st. The same treatment, intns et extra, is introduced. May 2d and 3d, pseudo-membranes lose in thickness, but gain in extent. Dr. Leblond does not follow this case, but heard that it had a quick recovery. She took per-chloride of iron internally.

Resorcin is a crystallizable substance similar to quinine, produced by the action of fused potassa upon some resins. Its antiseptic properties are analogous to those of carbolic acid. A one-per cent. solution arrests fer-

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mentation. It is neither caustic nor toxic, and can be used internally in doses relatively high (90 to 150 gr.) It is eliminated by the urine, which acquires a dark hue.

Dr. Leblond ordered his applications with the resorcin solution in glycerine, one to fifteen, to be made every two hours, night and day. This appears to have both a local and systemic effect; the pulse is slowed and the swelling of the glands disappears in a short time.

Death by Bromide of Potassium.—The Columbus Medical College, December, 1884, reports a fatal case by the use of bromide of pot. in 85 grain doses, every 4 hours, after it had been taken for four days.

Neuralgia of the 5th Pair.—A pledget of cotton dipped into a mixture of equal parts of fluid extracts of belladonna, viburnum opulus and gelsemium, introduced into the ear (previously cleaned), according to Csartoryski, produces almost instantaneous relief.

Carcinoma.—Injections of equal parts of turpentine and alcohol, made several times in the course of two months, in a rapidly growing carcinoma, caused the shrinkage of the tumor into a hard, inert mass. A multiple sarcoma disappeared after five weeks' treatment. The injection is painful and fever follows, lasting a day or two.—*Dr. Vogt, in Centralblatt fuer Chirurgie.*

Bichloride of Mercury in Gonorrhea.—Solutions of bichloride of mercury varying in strength from one to fourteen per cent., according to the amount of inflammation present, have, in the hands of Dr. Constantine Paul, obtained remarkable results. One part to 20,000 of water is sufficient to destroy the gonococcus, which he considers pathognomonic of gonorrhea.

Incubation of Diseases.—Vacher divides these various periods into five sections, as follows:

1. Shortest—One to four days—cholera (malignant), charbon, plague, catarrh, and dissecting fever.

2. Short—Two to six days—scarlet fever, diphtheria, dengue, idiopathic erysipelas, yellow fever, pyemia, influenza, pertusis, glanders, farcy, grease, croup, puerperal fever.

3. Medium—Five to eight days—relapsing fever, gonorrhea, vaccinia, inoculated small-pox.

4. Long—Ten to fifteen days—natural small pox, varicella, measles, rotheln, typhus fever, typhoid fever, mumps, malarial fever.

5. Longest—Forty days or more—syphilis and hydrophobia.

Small-pox ceases to be infectious in 56 days after the appearance of the eruption; modified small-pox in 35 days; scarlet fever in 49 days; diphtheria in 28 days; erysipelas in 35 days; typhus fever in 21 days; typhoid fever in 28 days, and mumps in 21 days.

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Periodical Change of Color of Hair.—A young girl, aged thirteen, of an idiotic type, was admitted into the asylum at Hamburg on April 1st, 1880, and died there in 1882. At the age of three years she began to be affected with spontaneous movements like those of St. Vitus' dance, which were chiefly confined to the head and upper limbs. Between her fifth and sixth year she had become the subject of well marked epilepsy. She was able, when four years old, to run round a table, but her powers of progression steadily diminished, and the lower limbs passed into a condition of chronic stiffness. When in the Asylum of Dalldorf (Hamburg) she had epileptic fits about every eight or fourteen days; besides, it was observed that she experienced alternations of agitation and calmness, each of about a week's duration. In the period of agitation, the turgescence and redness of the face were most pronounced, the pulse was full, the skin warm and actively transpiring, at the same time that the mental condition was one of extreme obstinacy. Further, it was often remarked that the color of the hair underwent decided changes; sometimes it was blonde and at others red, whilst the depth of these colors also varied. The alterations in color occurred in the brief space of two or three days; the first appearance of change was observed at the free ends of the hairs; the same tint of hair persisted for seven or eight days. Each of these periods of change of color of hair coincided with a phase of agitation or sedativeness. During the state of excitement the hair always had a red color, whilst pending the phases of stupidity the blonde tint prevailed. The case appeared to be one of genuine pathological change. The paler hair differed from the darker ones only in the presence of more numerous air spaces. The structure of the brain and spinal cord was much altered.

Mosquitoes and Yellow Fever.—The following propositions, which give in a condensed form the chief conclusions of Dr. Carlos Finlay's work on Yellow Fever, deserve consideration. Ordinary yellow fever is inoculable by means of the bite of the mosquito (Culex mosquito) on the third, fourth, fifth, and sixth days of its natural evolution. The disease cannot be transmitted by the agency of the insect before the third day or after the sixth, no matter what the severity of the disease. The peroid of inoculation of this experimental inoculation varies as widely as that of natural yellow fever. The duration and severity of the fever produced by inoculation by the mosquito appeared to be proportional to the number of the bites, and presumably to the quantity of matter contained in the insect's fang. The inoculation with one or two bites of the insect has never been followed by phenomena other than those usually met with in benign yellow fever. The results obtained up to the present lend hope to the suggestion that the inoculation by means of one or two *piqures* of the mosquito may confer immunity from the severe forms of the disease to

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those who have to dwell in its midst. The inoculability of the disease by the agency above indicated points to the value of guarding patients suffering from yellow fever against the bites of mosquitoes in order to prevent the spread of the malady.

Local Anesthetic.—A mixture of two drachms each of chloral and camphor, half a drachm of sulphate of morphine, and one drachm of chloroform, makes a useful anesthetic paint for minor operations. It should be applied several times with a camel-hair brush, and allowed to dry before the incision of the parts.—*Medical News.*

Laryngology.

Edited by GEO. F. HAWLEY, M.D., 125 State St.

Chromic Acid in Diseases of the Nose, Pharynx and Larynx.—Hering considers chromic acid to be a most useful remedy in the diseases of the nose, pharynx and larynx, but that it is rarely used from the fact that it cannot conveniently be applied and from fear of intoxication. He fuses the acid upon the end of a silver probe, as is done with nitrate of silver. Applied in this manner to the mucous membrane, it causes but little pain, and no symptoms of poisoning appear if used with proper precaution. The parts are to be thoroughly rinsed with water immediately after an application, and a solution of soda should be drawn if any of the acid is swallowed. It is particularly adapted to cases of chronic nasal catarrh and hypertrophy of the turbenated bones–*Archives of Otology.* The use of acids, such as chromic, nitric and glacial acetic have been long employed in this country by the leading laryngologists. The superiority of one over the other depends upon the locality where it is used rather than upon any actual advantages possessed. While we prefer chromic acid for post-nasal and pharyngeal applications, nitric or glacial acetic acid in our opinion is better for treating the nose. The pain is about the same which ever acid is used, although it varies in different individuals. Some mucous membranes require strong solution to effect a cure, while others demand the mildest of treatment. It is better therefore to begin with the weakest acid and if the result is not satisfactory apply another. The when and how to use a remedy is often of much more importance than what to use. Trankel showed to the members of the Berlin Medical Society a case of spasm of the facial nerve which had been cured by applications to the nose. The spasm had been of four years' duration and had been accompanied by pain in the nasal cavity of the same side. The introduction of a nasal speculum brought on a severe attack of spasm; touching the mucous membrane did the same. The spasm was cured by repeated appli-

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cations of the galvanic cautery. Sommerdrodt also reports a case where in addition to the reflex phenomena of a vaso-dilatatory nature, viz.: ædem of face and conjunctiva, due to irritation of the erectile structures in the nose, there was present paroxysms of sneezing and profuse secretion from the nose and tear gland; also reflex dilatation of the blood vessels of the mucous membrane of the bronchi; also reflexes which caused vomiting. There was as well reflex phenomena of the nerves of the skin, such as chilliness, rigors and blanching of the skin. The case was cured by the destruction of the erectile tissue over the turbenated bones. Sommerbrodt has also cured functional phonic glottis spasm, eleven cases of asthma, one case of whooping cough. He limits the cauterization always to the surface.

The Value of the Laryngoscope in Laryngeal Phthisis. —(*By F. C. Greene, M.D.*) A noted political economist has said that labor is improved in quality by division, and that the more skillful the mechanic the briefer is the time within which he can accomplish the given result. The rapid advancement of late years in all departments of medicine, and the high state of perfection attained in various special departments are now generally recognized by the entire profession. It can with truth be said of the specialist that he is not one who knows less of disease in general, but more of that particular class of diseases to which he has devoted most time and study. There is a general agreement in the opinion as expressed by the late Prof. Waldenbury, that laryngology is far more intimately connected with the other departments of medicine than otology, ophthalmology or even gynecology. In no other class of diseases not excepting that of the eye and skin, has objectiveness of investigation made so much progress or attained to such success as in that of the throat and nose. Dr. Geo. Johnson, Chairman of the Subsection of Laryngology, at the International Medicine Congress, at London, in comparing the ophthalmoscope and laryngoscope, claimed while admitting that the former might perhaps in the matter of diagnosis take precedence of the laryngoscope, that the latter possessed greater usefulness as far as treatment was concerned. This specialty dates its first complete recognition from the International Congress of 1881. Here over 100 of the most prominent laryngologists of the world assembled, and the papers and discussions upon this subject were admitted to be among the best presented to the congress. Since that time it has constantly gained ground, college after college adding to its corps of teachers one on laryngology. The day is not far distant when a patient with a persistent cough will be promptly referred to the laryngologist as one with an affected eye is sent to the ophthalmologist for opinion, advice and treatment.

Tubercular deposits often exist in the lung for some time before giving

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rise to positive sign of their existence in that locality, and an early diagnosis of the disease is of the greatest importance. It gives the sufferer from the malady the benefit of precious time in which to combat the process. It is possible in a great many instances to make a positive diagnosis by means of the laryngoscope before such diagnosis is justified by other physical signs or symptoms. It is true that the recent discoveries of Prof. Koch, of Berlin, has done much toward the recognition of this disease in its incipiency, but a thorough and careful examination with the laryngoscope will convey just as intelligent an idea of the abnormal process going on in the lung as will the microscope. One advantage of the laryngoscope over the microscopical mode of detecting the disease is that by its use the individual making the diagnosis can frequently arrest the disease by applying medicaments locally, thus avoiding all gastric derangements, caused by the use of solutions and syrups so much in vogue with the general practitioner. Lennox Brown says with the exception of laryngeal growths we know of no disease in which with the laryngoscope we can be so sure of our diagnosis. In not every case does the larynx become the seat of the phthisical process, but in such larynges the following sequence of symptoms will frequently be found, viz.: the mucous membrane of the larynx and epiglottis is pale and anæmic. So striking and special is this pallor that by its presence alone the condition of the lungs can be predicted.

The early objective symptoms of laryngitis, complicating pulmonary phthisis, are not often seen by laryngologists from the fact that during this stage there is comparatively little annoyance to the patient from this source. Then follow cough, congestions of the vocal cords and impairment of the voice. It is an important fact and should be recognized by every physician, that cough and impairment of the voice, however slight, if continued for any length of time have an important significance and demand attention. It is just here the chest symptoms and physical signs do not furnish ground for diagnosis. That the laryngoscope makes the diagnosis and enables treatment to be at once intelligently instituted. Finally we come to the distinctive period of the disease and find intense pain on deglutition and objectively the characteristic gray semi-solid infiltration of epiglotis, any epiglotic folds or both, upon which the ulceration is located. Beverly Robinson says, treat all cases in the beginning of laryngeal disease in patients threatened with phthisis by local application. By so doing some patients will never develop pulmonary phthisis. Even when a case has advanced to the stage of ulceration and oedœma, hopes of ultimate recovery should not be abandoned.

—EVERY minute 67 people die, and 70 are born, giving the birth excess at 3 per minute.

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Lupus on Nose and Face.—J. Herbert Stowes, M.D., in a paper before the British Med. Assoc. advocates the thorough eradication of the abnormal growth by scraping with a moderately sharp Volkman's scoop and the application of nitrate of silver. The diseased portion comes away easily while the healthy surrounding structures are too dense and fibrous to be disturbed. The scoop is applied with force and when bleeding is entirely arrested, solid nitrate of silver is pushed deeply in all the depressions. Pain and inflammation follow, but nothing unusual. Parts are dressed with lint, saturated with carbolized oil. Carbolized oil is allowed to run under the dressing the next day. When suppuration has begun fresh dressings are to be applied daily. Water should not be used in cleaning, only oil. Scraping should be done with aid of an anesthetic.

Vascular hypertrophy of nose.—He treats this condition by multiple punctures made by a bunch of scalpels. Fomenting the nose with water as hot as can be born, then squeezing nose between fingers plunges scalpel perpendicularly in the skin, not too deep, from base to apex; time between operations, five to six days. Vaseline smeared over nose the only external treatment. Internally, salines and alteratives. Alcohol positively prohibited. Time for cure, five to seven months. —*Wm. D. Babcock, M.D., Evansville, Ind.*

Treatment of Nasal Polypi.—As a valuable contribution to the therapeutics of this unpleasant condition, we are glad to note that Dr. Richardson, in the *Æsclepiad*, recommends the use of sodium ethylate in the treatment of nasal polypus. The caustic agent is applied by means of a probe made of soft cotton-wool, twisted into shape on the points of a pair of forceps. This cotton probe is saturated with the ethylate, and then plunged into the substance of the polypus. On removing the cotton it commonly happens that the patient can expel the whole mass of destroyed polypus, in a semi-fluid form, by blowing the nose sharply. A second application ought to be made with a view of destroying the base of the polypus. The mode of action is said to be sufficiently clear. The ethylate is decomposed by contact with the water of the polypus into caustic soda and alcohol; the latter coagulates the albuminoids, and the former acts as a powerful caustic. With the exception of some burning pain, no unpleasant effects seem to follow the use of this method.—*Peoria Med. Monthly.*

Adenoid Growths of the Naso-Pharynx.—Mr. Deighton read notes of the following case: C. L., aged 5½ years, a delicate-looking little girl, born in the West Indies, of English parents, came to England three years ago, where she had measles very badly, and suffered from a profuse purulent discharge from her nose, but did not have any ear-complications; since then she had suffered more or less from stuffiness of the

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nose, which had increased of late, until now she was quite unable to blow her nose. She always slept with the mouth open, snored, and even in the daytime continually had her mouth open, and breathed noisily. Of late she had been getting somewhat deaf. On examination of the anterior naries, the mucous membrane of the inferior turbinated bones was not hypertrophied, or unnatural in color. The tonsils were only slightly enlarged. Rhinoscopy was impracticable, but, on examining the vault of the pharynx, a large mass of postnasal growths, which bled very readily, was detected by the finger. These were removed by Lowenberg's forceps. In order to re-establish respiration through the nose, the mother was told to check the child whenever she was seen to be breathing with the mouth open, and a chin-rest, with tapes to tie over the head, was ordered to be worn during sleep. This treatment was entirely successful. Mr. Deighton then read notes of a similar case which had only just recently come under his notice—of a young lady of about 30, in whom all the symptoms were much more advanced, and considerable deafness had resulted—the watch being heard at a distance of only one inch with the right ear and four inches with the left. Mr. Deighton remarked on the importance of early treatment, and of the often disastrous results, as regards hearing, of neglect, and urged the importance of examining the naso-pharynx in all cases of throat-deafness and obstructed nasal breathing with enlarged tonsils.—*Cambridge Med. Society*, Dec. 5.

Non-Penetration of the Lining False Membrane: An Unnoticed Danger in Tracheotomy.—In a recent operation for laryngo-tracheotomy, on a child about four years old, for croup, where the general condition and the absence of lividity seemed to promise a favorable result, I was baffled at finding, after the insertion of the tube, that but one feeble inspiratory effort with the well known "whiz" of entering air was made, and that artificial inflation failed to distend the lungs. Though an examination with the finger showed that the tube had entered the windpipe, artificial respiration was fruitless, and I had the pain of seeing my little patient die during the operation. A necropsy revealed the difficulty; the opening into the larynx had been made rather on the right side of the median line, and Fuller's bivalve tracheotomy-tube had passed down between the trachea and the false membrane, thus pressing together the sides of the lining tube of false membrane, and preventing the passage of air. A freer opening into the larynx or trachea would render it less likely that a false membrane could escape division; and I hope, by placing this failure on record, that more stress may be laid on the importance of this point, as insisted on in the excellent text-books of Holmes or Bryant, where, though a free opening of the normal tissues is recommended, no mention is made of the risk of the cannula in its passage pushing

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before it the undivided false membrane, as happened in this instance. Nor is the danger alluded to in the discussion which followed Dr. Buchanan's paper on tracheotomy, at the International Medical Congress of 1881. Thus, from the silence of those who have frequently operated, it would appear that this source of danger has not often been met with.—*Ashby G. Osborn, in British Med. Journal.*

Acute Laryngeal Catarrh.—W. Cheatham advises the following treatment in acute laryngeal catarrh: Keep the patient in bed in a room having a temperature of 75° to 80° F. The air should be moist and medicated by evaporating a mixture consisting of one tablespoonful of tr. benzoin co., one dessert-spoonful of turpentine in one pint of water. This is to be evaporated by means of two teakettles placed over a gas stove—each kettle containing the amount as given, the benzoin and turpentine being added every three hours. In addition, the patient is every two hours to cover his head with a towel, place his face near the kettle, and inhale the steam for ten minutes. Over the larynx externally apply frequently the comp. iodine ointment. When the acute symptoms disappear, use by means of a brush or cotton, alum grs. xv. aq. ℥i.—*Louisville Med. Jour.*

It is hardly necessary in all cases of acute laryngitis to adhere strictly to this form of treatment. Ordinarily an inhalation of tr. benzoin co. ℥i in a pint of hot water at a temperature of 140° F., two or three times a day, will be sufficient to relieve the patient in the acute stage. The metallic coil of Leiter may also be used to advantage about the neck, with either hot or cold water. We have of late employed a four-per cent. solution of muriate cocaine to the larynx in those cases which have come under treatment at the beginning of the attack.

Diffuse Round Cell Sarcoma.—An interesting case of diffuse round cell sarcoma, involving the posterior nares, vault of the pharynx, soft palate, pallar of the fauces, right tonsil and lower pharynx, was reported by Bosworth in the *Medical Record* for Jan. 17. It was removed piecemeal by means of Jarvis' snare, it taking six months to effect a cure. The galvano-cautery was for a time employed, but it so aggravated all the symptoms, causing the growth to assume such an angry and threatening appearance that it was soon abandoned for the cold snare. Every precaution was at once taken to avoid all further unnecessary irritation to the parts, the snare alone being used. As each piece was removed the parts were sprayed with a carbolized solution, and at the end of each operation the cut surfaces were coated with vaseline. Bosworth lays the success of the treatment to his method of operating, viz., removing the growth by piecemeal. In our opinion his success was due to the employment of such means which would produce the least

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irritation, and consequently the least reaction. If the tumor could have been removed at once the same result might have been obtained in a much less time. This unfavorable condition, excited by the use of the galvano-cautery, only tends to confirm the opinion expressed by us in a late number of this journal, that in all operations for the removal of tumors or outgrowths Jarvis' snare should be used in preference to the galvano-cautery. Bosworth's experience has been our own in several instances. This case is also interesting from another standpoint. It shows what patience, skill, and care will sometimes accomplish, bringing an almost fatal case to a successful termination.

Dermatology.

Edited by HENRY J. REYNOLDS, M.D., 2200 Michigan Ave.

Remarks on Cutaneous Therapeutics.—Dr. P. C. Jensen, at a recent meeting of the Chicago Medical Society, read a paper under the above title, from which our space only admits of the following abstract:

Inasmuch as the integument retains many of its primitive characters from early embryonic life, when it dipped into the interior of the body by deep folds and involutions to be subsequently differentiated into organs for special function, as alimentary canal and accessory organs, furnishing prolongations to the formation of spleen, kidneys, bladder, external and internal genital organs, etc., and owing to the fact that in all instances the excretory organs consist essentially of limitary membrane, forming part of the integument of the body, or its involutions, that the lachrymal, salivary, pancreatic and mammary glands are in like manner composed of a continuation of the limitary membrane of the true skin, or of the mucous membrane lining the alimentary canal involuted into tubes and follicles, the free surface of which is covered with epithelial cells, etc.; it is from this early embryological relation of the true skin to internal organs which furnish us so essential a factor in therapeutics of disease. In cutaneous diseases, as in lesions of internal organs, it is worth remembering that much of the functions of disabled organs can be carried on by compensatory action of neighboring organs. In congestion of the kidneys we relieve and deplete by bringing the skin and bowels into energetic action, and by removing the burden we rest the overworked kidney; conversely, eliminating by all the emunctories is essential in treatment of diseases of the skin. * * * Upon the back of a horse Colin caused water, impregnated with potassic cyanide, to drip for five hours; the percussion effected destruction of the sebaceous matter, with absorption of the cyanide, and poisoned the animal. In Vienna, patients have remained

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immersed in a bath for weeks and months, without any perceptible degree of absorption taking place. Usually, the small quantity absorbed is either introduced by points of transition between the skin and mucous membrane, or the orifices of the sebaceous and sudoriporous glands. When the cutaneous surface of a limb is immersed in putrid gases, absorption takes place (Bichats) and the poison is subsequently eliminated by the bowels. The rate and degree of absorption of any medicine will depend largely on its power of diffusion. Physiologically, the skin may be considered a colloidal septum, on one side of which lie the blood-vessels containing an alkaline fluid, while an acid is on the other side, a condition most favorable to asmosis. Medicinal substances in aqueous solution slowly permeate the skin to enter the circulation. Alkaloids dissolved in chloroform are readily transferred through the skin into the blood-vessels, while alcoholic and aqueous solutions are either not at all or very slowly absorbed (Waller, whose observations were made with chloroformic solutions of atropia, aconitia, morphia and strichnia). The same physiologist determines that alcohol, mixed with chloroform, did not retard absorption, but alcohol alone caused an asmotic flow. With these remarks as a foundation, we proceed to the "therapeutics in local treatment of skin disease," which consist, for sake of convenience, of:

1. Protectives—air to be excluded when its contact is injurious.
2. Cleanliness through ablutions, removal of disease products, etc.
3. Measures which tend to check or limit liquid disease products, whether sanguineous, sebaceous, serous, or puriform.

The remedies should act directly without injuring the surrounding parts. To fulfill these requirements we have emplastra, anguenta tincturæ, dry powders, alcoholic and etherial solutions, chloroformic solutions, oleo-polmitates, etc., and the curative agents most commonly used in these forms are the oxides and salts of Pb., Ag., Hg., Zn., Cu., Al., also various astringents, sedatives, and anodynes, of organic origin. The more recent local remedies are salicylic acid, goa or aroba powder, chrysarobin (Balmanno Squire), pyrogallic acid (Jarisch) and naphthol (Kaposi). Tilbury Fox uses goa powder formed into a paste with water, applied to psoriasic patches, and retained in position with collodion. Rick recommends chrysarobin gelatin of different strength, and applies glycerine over the gelatin after application. Unna proposes chrysarobin plaster. Mülle, ointment of chrysarobin spread on muslin. Dr. Kohn uses a solution which he terms traumaticin, as,—

℞ Refined Gutta Percha, part one.
Chloroform, parts ten.

The following advantages are claimed for it: It forms a thinner and more delicate covering than collodion or gelatin, causing neither ten-

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sion nor pain. Traumaticin is of itself a neutral covering and protective remedy. Ten per-cent. solutions of it when applied to large surfaces, do not cause irritation; besides, it produces more uniform pressure than collodion, glycerine, or gelatin. The writer has treated a number of cases of psoriasis and obstinate chronic eczema substantially as follows: In most cases there were present either a debilitated constitution, gouty diathesis, anæmia, neurasthenia, etc. Particular attention was paid to each constitutional dyscrasia. For removal of waste toxic debris, getting rid of sebaceous matter, etc., an alkaline lotion was always first thoroughly applied; which, by accomplishing the above, or otherwise, he claims, favors osmosis and absorption and thereby serves a double purpose as a preparatory treatment. The various indications as to the real treatment are then carried out by some of the above mentioned remedies or methods, or otherwise if so indicated.

Dermatitis Herpetiformis.—Prof. Dubring regards as properly coming under this head in addition to the impetigo herpetiformis of Hebra and the herpes gestationis of certain writers, also the "herpes circinatus bullosus" of Erasmus Wilson;[1] the "pemphigus prurigineux" of Hardy;[2] the "pemphigus" of Klein;[3] the "pemphigus circinatus" of Rayer;[4] the "herpes phlyctaenodes" of Gibert;[5] the "pemphigus aign pouriginosus"[6] of Chausit;[6] and the "pemphigus compose" of Devergie;[7] also certain cases of so-called "hydroa"; for example, the cases reported by Handfield Jones[8] and Bulkley,[9] and that of "Florence S," described in the *British Medical Journal*, 1870. Likewise such cases as that of Oswald,[10] reported with the heading "a peculiar skin eruption occurring during pregnancy"; and of Leigh,[11] a "bullous eruption of a peculiar character." The case of Jarisch,[12] designated "herpes iris," and the case of Meyer,[13] "a fatal pemphigus-like dermatitis," and likewise some cases of so-called pemphigus, especially of "pemphigus pruriginosus," might be more properly regarded as examples of dermatitis herpetiformis.

Psoriasis—A Clinic at the College of Physicians and Surgeons of Chicago. By Henry J. Reynolds, M.D., Professor of Dermatology.—This man, aged 40, otherwise healthy, comes to us with a history of having had an eruption on his body for twenty-two years. He exposes an arm, and we find the eruption most marked upon the back or external

1. Diseases of the Skin. Sixth ed. London, 1867.
2. Lecon's Sur. les Mal. de la Peau. 2nd part, p. 136. 2nd ed. Paris, 1863.
3. Allg. Wein. *Med. Zeitung*, August, 1867; quoted in *Jour. Cutan. Med.*, July, 1868, p. 208.
4. Treatise on Diseases of the Skin. English translation. London, 1835, p. 219.
5. A Practical Treatise on the Special Diseases of the Skin. English trans., Lond. 1845, p. 118.
6. Annales des Maladies de la Peau et de Syph. March, 1852.
7. Mal. de la Peau, p. 309. Paris, 1857.
8. *Med. Times and Gaz.*, Sept. 6, 1873.
9. Archives of Derm., April, 1877.
10. *Lancet*, June 10, 1882, p. 951.
11. *Lancet*, Jan. 6, 1883, p. 11.
12. Viertlj. für Derm. U. Syph. 2u. 3 Heft., p. 195, 1880.
13. Archiv. für path. Anat. u. Phys. Nov., 1883, p. 185.

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surface, particularly so at or near the olecranon. The first striking thing, we observe about it, is its pecular dryness, and its scaly condition. Upon scratching these scaly patches a little, we find that they assume a white, shiny, silvery appearance. Now, this of itself always suggests psoriasis. I think there is no other disease of the skin that gives just this character of scales, and when once familiar with the appearance of which, a diagnosis of psoriasis might almost be based upon this one symptom alone.

But while this of itself might be sufficient to base a diagnosis upon, it would be a very bad rule to follow, for we have other characteristics that are fully as valuable diagnostic points as this, and while any one of them alone might be sufficient to satisfy the mind of the physician, a combination of all is better and is the proper rule to follow in making a diagnosis of anything. Do not base the diagnosis upon one well marked symptom alone, but, hurriedly at least, run over the combination before committing yourself. Well, we now find upon removing the scaly patch, that we have what would scarcely have been expected from the mild, inactive appearance of the parts before this removal, a very red patch, and in this red patch we notice small pinhead-sized droplets of blood oozing out. Now this of itself again is almost pathognomonic of psoriasis. We further notice that the patches are round, not elevated, with well defined margins, and that the skin between them is perfectly normal. Now you will recollect that I have told you that you should always have an accurate knowledge of the condition of the skin of the entire body in diagnosticating skin affections, either from the statement of the patient or from personal examination (very preferably the latter). We find here and there, all over the body, the eruption more or less symmetrically distributed, with, however, a preference for the extensor surfaces. The patient states that he is generally freer from the disease in the summer than in the winter, and that it gives rise to no itching or other subjective sensation of any consequence. These symptoms are also characteristic of psoriasis. Now from the combination of symptoms just considered, viz.: the white, shiny scales, the dry character of the eruption, the round, isolated, red, bleeding patch on removal of the scales, its involving the entire body more or less, its preference for the extensor surfaces, its tendency to disappear in the warm and return in the cold weather, and the absence of itching, which embraces almost everything that is characteristic of the disease, we may with absolute positiveness render a diagnosis of psoriasis. Now some of these lesions on the trunk, from destruction of the scales by frequent washing and previous treatment, resemble the lesions of the macular syphiloderm, and he indeed states that he has been treated for secondary syphilis; but if the man had syphilis

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half a dozen times, (which would be impossible) we know from the combination of symptoms in the case that he has psoriasis nevertheless; besides, he gives no syphilitic history, nor any of the numerous syphilitic symptoms more than that just referred to.

The eruption can very speedily be cleared up by appropriate treatment, but the great trouble in this disease is its tendency to return. We will first, for the purpose of getting rid of the scales, which should always be accomplished before the treatment proper is begun, apply carbolized ointment twice a day for two days, then the entire body will be bathed in hot water with plenty of soap and friction. The same ointment will again be applied for two more days and followed by the same bathing process. We will then have a chrysarobin ointment, of grs. xx to ung. aquæ rosæ ʒi, applied twice a day to every individual lesion on the body. The chrysarobin should be suspended and the former process substituted about every week or ten days. Arsenic may also be given internally in this disease, beginning with about five drops of Fowler's solution, three times a day, and gradually increasing as indicated by the effects.

For the prevention of the return of the disease frequent bathing with hot water and green soap, and measures which tend to keep the skin active, are indicated.—*Jour. and Exam.*

Surgery.

Edited by G. FRANK LYDSTON, M.D., 125 State St.

Actinomycosis in Chicago.*—It was with great interest that I perused a report of the proceedings of the Chicago Medical Society, containing an account of the cases of actinomycosis discovered by Dr. J. B. Murphy, which appeared in the columns of the *New York Med. Jour.*, Jan. 3, and I confess that I was somewhat surprised at the prompt editorial acceptance of the cases as genuine, which appeared in the same issue of the *Journal.* Although of no pretensions as a microscopical expert, I do not think it ill advised for me to state my experience with one of the cases reported, nor do I consider it presumptuous, as seems to be the opinion held in certain quarters, for the general practitioner to give an opinion based upon clinical experience, even in the face of the *ipse dixit* of some microscopists. In a spirit of fairness and with a desire for self-justification, I think I may be permitted to state a few facts regarding the second case reported by Dr. Murphy. Some eight or ten weeks ago, a young man by the name of Thomas Carroll, consulted me regarding a swelling be-

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neath the angle of the jaw upon the right side, the history of which he gave as follows, viz.: Some eight months prior to his visit to me, and while he was living in Ireland, he was taken with a severe toothache, apparently in one of the molars in the lower jaw upon the right side. This lasted for several weeks, his general health being perfect at the time, and finally subsided. At this time, however, a swelling appeared beneath the angle of the jaw upon the same side. This he said was at times quite painful, and at others appeared to improve, the swelling at such times subsiding considerably. He finally came to America, and two months before consulting me, consulted Dr. Murphy, who "lanced" the swelling, and subsequently "scraped" it at different times. The incision finally healed, the lump still remaining, however. A few days before I saw the young man, the swelling had grown much worse, and on the day previous to his visit to me, he again consulted Dr. Murphy, who repeated the "lancing" process, and inserted a drainage tube. He was told by the doctor that it would be necessary for him to enter the county hospital and have an operation performed, as his disease was due to his having at some time previous to the commencement of the trouble eaten some "poisonous meat which had entered the carious tooth," that had been known to exist during the doctor's attendance upon the case. Not relishing the prospect of a serious operation, even if gratuitously performed, the young man determined to seek further counsel and accordingly visited me. On examination I found an inflammatory swelling the size of a small hen's egg beneath the jaw upon the right side. This was surrounded by quite an area of infiltration, the tissues being hard and brawny. In the center of the swelling, a small incision had been made, and within it was a short piece of rubber tubing. There was no distinct abscess cavity, but merely an opening in the center of the swelling, of sufficient size to accommodate the drainage tube. There was a moderate amount of thin purulent discharge, of the appearance usually seen when a phlegmon or adenitis is incised before distinct suppuration has occurred. The history of the case, with the unsuccessful result of the treatment which had been carried out for two months previous to my examination, and the appearance of the swelling were sufficient to warrant me in suspecting precisely what I found upon opening the patient's mouth, viz., a carious molar just above the abscess. I called the attention of several professional gentlemen to the patient, and without mentioning the name of the previous attendant, expressed my surprised that the case had not been diagnosed and successfully treated. In common with the gentlemen who saw the case, I wondered what particular operation had been suggested for such a simple affection. Dr. Austin kindly extracted the remnants of the tooth, and I then bound a piece of compressed sponge upon the swelling, leaving no

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provision whatever, for drainage. Considering the golden opportunity which I now had, for the treatment of a case of actinomycosis, such an exhibition of incompetence upon my part was unpardonable. Considerable improvement in the case was evident upon the following day, and in the course of four or five days, the discharge had ceased. As the opening was healing rather too rapidly, I enlarged it a little the third day after extracting the tooth. At the end of two weeks nothing remained save a small lump the size of a marble, and in three weeks there was nothing but a scar to show that any trouble had existed. At the present time the patient is perfectly well. His general condition has been good ever since the trouble commenced, and his appearance has been the perfect picture of rugged good health. Some ten days after I first saw the patient I was informed that a reporter had been seeking for me on some very important business connected with a case of "disease of the jaw," which I had been treating. I was at a loss to understand the meaning of this until the following day, when some of my friends informed me that an interview with Dr. J. B. Murphy had been published in the daily papers, in which it was stated that the case of Thomas Carroll was one of actinomycosis, and that I had failed to diagnose and report the case. I afterwards saw the article in the paper, and found a good half column devoted to the "second case discovered by Dr. Murphy who was the first to discover the disease in America." I was interviewed, and the patient being present, I exhibited him, and at the same time gave my opinion of the case, as I think I was justified in doing, in self-defense. In a later issue of the paper, Dr. Kerber, "who had studied the disease in Vienna, with Bollinger," expressed the view that "any physician who said that the case was not one of actinomycosis, either did not know what he was talking about, or deliberately falsified, that I had never seen a case of actinomycosis, etc." These statements seemed to me quite emphatic, the more especially as I had never heard of the gentleman before, and therefore could not have trodden upon his professional corns. The case was afterwards reported with the alleged first case "discovered" by Dr. Murphy, to the Chicago Medical Society, and an unsuccessful attempt was made to exhibit specimens under the microscope. A successful exhibition of specimens from the bovine "lumpy jaw," however, was made by Dr. Belfield. I was unfortunately prevented from attending the meeting, and participating in the discussion. All the city papers contained double column reports of the article on the following day, and significant allusions were made to my failure to materialize at the meeting. Not caring for further newspaper fame, and appreciating the fact that somebody had a monopoly of the reportorial ear, I have been waiting for a professional report of the

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case, and meanwhile keeping silent. The report in the *New York Med. Jour.* gives me an opportunity to speak.

In the first place, I desire to state that I have had no experience with actinomycosis in the human subject, and I have seen but few cases in cattle of alleged "lumpy jaw." My knowledge of the disease is based entirely upon the descriptions given by Dr. Belfield, and by the authorities quoted by Dr. Murphy. I do however, claim to know disease secondary to alveolar abscess when I see it, and to possess eyesight sufficiently keen to observe those peculiar appearances of actinomycosis, which, should they exist, would not require the microscope for a presumptive diagnosis, as is admitted by even those who support Dr. Murphy. Now, it is easy for me to appreciate the fact that my failure to examine the discharges with the microscope, is an evidence to the gentlemen of the opposition, of my incompetency to pass an opinion upon the case, but in the face of their own admissions that the microscopic characters of actinomycosis are unmistakable, such an argument is not of great weight. It may be naturally asked why I did not make a microscopical study of the case. I would ask any surgeon of experience if he would have done so in a case apparently so simple, in which the diagnosis was so clear, and so plainly corroborated by the result of common sense treatment? The fact is, that the case was practically well in a few days, and by the time the sensational newspaper reports appeared, there was nothing to examine. Now why did Dr. Murphy make a microscopical examination? Simply because he had failed to cure the case, and was desirous of finding the obscure cause of his failure. What he found, it is not my province to say, but he began treatment by the curette, and the wound made by the knife finally healed; the lump however, remained and eventually a relapse occurred and the case became worse than ever. An operation was now proposed, and it is to be presumed would have been performed had the patient submitted. That it would have been an operation of some gravity may be inferred from the line of treatment carried out in the first case of "lumpy jaw" seen by Dr Murphy. The gentlemen who saw this second case, claim that it was cured before it fell into my hands, and quote five cases reported by Rosenbach, as having been cured by incision and drainage. That this argument is weak, is shown by the non-success attendant upon two months' treatment by incision and scraping, and the fact that the day after the drainage tube was inserted, I removed it. If the case was "cured," why operate? My successful result from simple extraction of the tooth, shows that whatever may have been the character of the case, an operation would have been an uncalled for procedure. If the case was actinomycosis, it seems to me that in common with all parasitic diseases, either complete extirpation or thorough destruction of the

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cause of the disease would have been necessary for its cure. Was this accomplished by extracting the tooth? Was not my treatment by compression with sponge, the very worst that could have been devised for the cure of actinomycosis? The parasites had not been removed before the case fell into my hands, else the swelling would have disappeared, and an "operation" would not have been indicated as was stated by Dr. Murphy, the day before I saw the case. I should like to ask why the gentlemen who saw the case with me, and myself failed to perceived the peculiar gross appearances of "lumpy jaw," which have been described by Dr. Murphy and his supporters? I do not deem it at all presumptuous to question the judgment of a practicing surgeon, who fails to remove the source of irritation in such cases, especially when he knows that it exists, and surely if we are justified in impeaching his surgical judgment, we may with propriety doubt his microscopical accuracy, for I believe that the skillful use of the microscope requires considerable scientific ability. If the microscope necessitates such lamentable failures as attended the treatment of this case prior to the extraction of the tooth, it were better to throw it away. That an exact scientific diagnosis should lead to failure, and the diagnosis of a non-expert in actinomycosis should lead to a successful line of practice, is a trifle paradoxical. But I think we may question the "scientific" nature of the microscopical studies made in the case in question. I am under the impression that no true scientist ever says, "it is so because I say so, and I care not what others may think about the matter," or "he who does not think with me, is either a knave, or an ignoramus," but this was precisely the position assumed by Drs. Murphy and Kerber. Even Koch is compelled to support and defend his views. Now I am willing to believe that the views of these gentlemen as to the diagnosis of these alleged cases of "actinomycosis," were perfectly honest, and will not dispute the genuineness of the first case, particularly as Dr. Belfield, whose ability and honesty are unimpeachable, states that he saw the case and confirmed the diagnosis. It does seem singular, however, that two cases should fall into the hands of the same surgeon, within a few months, the more especially as one of them must have originated in Ireland, where as yet the disease has not been discovered. A peculiar fact regarding the second case deserves mention, viz.: that the specimens presented to those who confirmed the diagnosis were not removed in their presence, nor did they at any time see the case. Then, too, the specimens which were advertised to appear before the Society, failed to present themselves in a form sufficiently definite to be recognized by any one but Dr. Murphy. The fact that full reports of the cases, and the remarks of those concurring in the diagnosis appeared in at least three of the daily papers, while little notice was taken of the remarks of

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those who disputed it, is significant, to say the least. It seems to me that the scientific aspect of these cases has not yet received any attention. In the minds of any thinking investigator, who is seeking for light upon a rare and probably malignant disease, the average mortality of which, according to Dr. Murphy's report, is 60 per cent., certain questions are apt to suggest themselves in the presence of such cases as those under consideration. In the first case, he would perhaps examine the "sulphur colored-granules" microscopically. He would then, irrespective of the result, at least if he honestly considered the welfare of the patient rather than a little lustre for his reputation, and understood the rudiments of surgery, extract the carious teeth, which it is admitted were known to exist in the first case. This, however, was not done by Dr. Murphy until the more serious operation was performed. If after a reasonable time a cure were not effected, our scientist would seek a method of cure more radical in character. If he should meet with a second case which he considered precisely like the first, (even admitting that he had failed to extract the teeth, but had cured the case by operation), and should treat it unsuccessfully for some weeks; if he should suggest an operation similar to that performed in the first case, and the patient having refused consent should fall into the hands of another gentleman, and his disease be cured by the simple extraction of the carious tooth, he would be apt to reflect still more seriously. In fact, a feeling of mortification might quite naturally be first experienced. He would then probably doubt the accuracy of his observations, and seek for an explanation of his error. In the first place, was the mycelium seen by him precisely identical with that seen in the serious affection, "lumpy jaw," or was it a new fungus, so nearly like it as to be mistaken for it? Such a circumstance would be nothing unusual in regard to a new field of study. Having satisfied himself that the mycelium was the same, he would naturally ask whether it might not be a mere coincidence in both "lumpy jaw" and the suppurative affections secondary to carious teeth. This would imply that the true cause of "lumpy jaw" was as yet unknown, and that "actinomycosis" was a misnomer. He would then probably investigate further before publishing his dictum, and thus grasp the real opportunity for scientific distinction. All this he would do before he attempted to overthrow the magnificent edifice reared by the clinical experience of thousands of surgeons, with the mere assertion that he "microscopically saw" the cause of the disease, and that his management of the case was consequently correct. In neither of the cases reported by Dr. Murphy was his treatment "surgical," in the true sense of the term, for the first principle of treatment of abscesses, or osseous troubles in the vicinity of the jaws is to remove all sources of irritation which so often consist in diseased teeth. I think that almost any sur-

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geon whose views are unprejudiced, will, in the light of the history of the second case of "lumpy jaw," doubt the propriety of the extensive operation practiced in the first case, irrespective of its character. It seems to me a little singular that Dr. Murphy has resorted to the argument that certain cases of actinomycosis are very mild, and may be cured by very simple means, in evidence of which he cites a series of five cases reported by Rosenbach. Possibly Rosenbach was mistaken, for that he would meet with a succession of cases of a mild type, of so rare and malignant a disease, is open to question. If, however, this report be true, and Dr. Murphy was cognizant of it at the time he proposed an operation upon Carroll, he being an expert, ought to have known that an operation was superfluous. If he did not know of Rosenbach's cases, he was not capable of differentiating the mild from the malignant types of the disease, and consequently his claims to expertness in lumpy jaw would fall to the ground. If actuated by a desire to cure the case, any one familiar with surgical principles would have tried the effect of extraction of the teeth, irrespective of the character of the disease. The statement that the case of Carroll was one of the simple forms of actinomycosis, is a lame argument, for of this much I am absolutely certain, viz.: that the treatment of the case based upon the diagnosis of "lumpy jaw" was an utter failure, while the simple extraction of a carious molar was a perfect success. I am also positive that the case would never have been cured in any other way, but would have gone on to caries of the jaw, and the formation of troublesome sinuses such as every surgeon and dentist very often sees. That the physician knows little of diseases of the teeth and jaws is a byword with dentists, and is a source of profit to them; and as far as I am able to see, the researches of some of our American experts in actinomycosis have not thus far tended to correct the evil. In conclusion, I will say, that it behooves those who have pretensions to fame as original discoverers, to be a trifle circumspect, for reported wonderful discoveries might possibly be mistaken for a desire for unmerited notoriety.

125 State St., Chicago.

Micrococci in Relation to Wounds, Abscesses and Septic Processes.—In a report to the British Medical Association, Dr. W. Watson Cheyne gives the following summary:

1. There are various kinds of micrococci found in wounds treated aseptically, differing markedly from each other in their effects on animals. They agree in growing best at the temperature of the body, and in causing acidity and sweaty smell in the fluids in which they grow. The experiments show that cultivations may be carried on in fluids with accuracy, provided the precautions mentioned be observed.

2. The micrococci tested in these experiments grew best in materials

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exposed to oxygen gas. They grew only with difficulty in the absence of oxygen. Eggs were not good pabulum.

3. Their effect on animals was not altered by growth with or without oxygen.

4. The effects of these micrococci on rabbits and man were not similar, some of the most virulent forms for rabbits causing no deleterious effects in wounds in man.

5. The kidney is apparently an important excreting organ for organisms.

6. Organisms not capable of growing in the blood may yet cause serious effects by growing in the excretory canals. This may explain some cases of pyelitis.

7. Where an organism is not markedly pathogenic, it may be necessary to introduce a large quantity before morbid changes are set up.

8. Suppuration is not always due to micrococci; it may be caused by chemical irritants, such as croton-oil.

9. Micrococci are always present in acute abscesses, and are probably the cause of them.

10. In some cases the micrococci are the primary cause of the inflammation and suppuration, as in pyæmic abscesses; generally, however, they begin to act after inflammation has been previously induced.

11. This inflammation may be caused by an injury, by the absorption of chemically irritating substances from wounds, by cold, etc.

12. There are several different kinds of micrococci associated with suppuration.

13. Micrococci cause suppuration by the production of a chemically irritating substance, which, if applied to the tissues in a concentrated form, causes necrosis of the tissue, but, if more dilute, causes inflammation and suppuration.

14. The condition in wounds and abscesses are not the same, inasmuch as in the former there is opportunity for mechanical and chemical irritants to work.

15. There is no reason for denying the existence of "antiseptic" suppuration.

16. Tension may also cause suppuration, but it is perhaps most frequently aided by the growth of micrococci. These organisms need not be of a very virulent kind. It is also probable that the products of inflammation are themselves irritating and capable of exciting or keeping up inflammation.

17. The micro-organisms of septicæmia, of pyæmia and of erysipelas, are different from one another and from those of abscesses. In erysipelas the micrococci grow in the lymphatic spaces; in pyæmia they grow in the blood to form colonies and emboli; in septicæmia they may only grow

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locally, the symptoms being due to the absorption of their ptomaines; or if they grow in the blood they do not form colonies and emboli. Septicæmia may also be due to other organisms besides micrococci.

18. There are no facts to support the view that it is the same micrococcus which, under different conditions, causes these various diseases. The experiments of conversion of innocent into malignant forms, and *vice versa*, are unreliable.—*Brit. Med. Jour.*, Oct. 4.

Lateral Lithotomy in the Female.—Nundibhai, a girl aged nine years, was admitted into the Indore Charitable Hospital on March 6, 1875, suffering from vesical calculus. As the calculus was too large for its removal by lithectasy in a child of this age, and not likely to try vaginal lithotomy in so young a patient, it occurred to me that it would be practicable to remove the stone by modification of the ordinary operation of lateral lithotomy in the male. Accordingly, on March 9, I placed the girl in the position of lateral lithotomy, introduced a curved staff and made an incision in the left labium, parallel with, and close to, the ramus of the pubis. This incision I deepened by dissecting inward and upward in the direction of the neck of the bladder, carefully avoiding wounding the vagina, till, at the membranous portion of the urethra, I felt the groove on the staff. On this, I divided the neck of the bladder, introduced the forceps, and removed, without any difficulty, a stone three-quarters of an inch in diameter. The after-progress of the case was most satisfactory. For some days, all the urine was discharged through the wound, which rapidly contracted, and healed within three weeks. The girl was discharged cured on April 1st.—*Beaumont, in British Medical Journal*, October, 1884.

Stretching the Intercostal Nerves.—Dr. L. von Lesser, of Leipzig, has recently reported a somewhat remarkable case of intercostal neuralgia and of mastodynia treated successfully by stretching of several intercostal nerves. The patient, a woman aged sixty-one years, and the mother of eight children, had suffered during seven years from a feeling of compression of the thorax, very severe paroxysms of darting pains along the intercostal spaces on both sides, but more intense on the right, and neuralgic attacks in the mammæ and nipples. Through the intensity of these paroxysms, which came on usually at night, she was prevented from sleeping, and her sufferings were so severe that she became very anxious that some operation should be performed which might give relief. Just below the ribs on the right side was a fatty tumor of the size of a plum; but this was soft and free from tenderness, and clearly not the cause of the neuralgia. On pressure over each of the much-atrophied mammary glands a few drops of fluid, resembling milk, could be forced out through the nipple. This fluid, which was secreted more abundantly

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during the paroxysms of neuralgia, presented under the microscope an abundance of oil-globules of different sizes, and a few round cells containing oil-globules. As the neuralgic pains were much more severe on the right than on the left side, the operation was performed on the right intercostal nerves from the fourth to the tenth. The incision was begun in the axillary line, and carried obliquely backward and downward from the upper margin of the third rib to the lower margin of the tenth rib. The processes of the serratus magnus muscle having been divided, and the external intercostal muscles separated from the lower margins of the corresponding upper ribs, the seven intercostal nerves were exposed, and each forcibly stretched in a centripetal and a centrifugal direction. The patient made a very speedy recovery. From the date of the operation she was able to sleep soundly at night, and complained only of occasional slight "dragging pains" on the right side of the chest, and a feeling of compression over the lower intercostal spaces. Up to the time of her discharge, on the eleventh day after the date of operation, there had not been any return either of the paroxysms of pain or of the mastodynia.—*Deutsche Med. Wochensch.—Pract.*

Corrosive Sublimate as a Surgical Dressing.—It has been rumored that Sir Joseph Lister had withdrawn his great confidence in antiseptic dressings. This seemed strange to those who recalled the great enthusiasm with which this great teacher had advocated what we have come to call "Listerian precautions." In an address delivered at the opening of the Medical Society of London, and published in the *British Medical Journal*, October 25, 1884, Sir Joseph tells us that several instances have recently occurred, of results deviating from his typical experience in antiseptic treatment, such as he was in no way prepared to meet with, and in one case a fatal event ensued. Casting about for the cause of these failures, he came to the conclusion, which is a very plausible one, that volatile antiseptics, such as he had been using, principally eucalyptus and carbolic acid, were unreliable, owing to the very fact of their volatility, which not only rendered their proper preparation by the manufacturer very difficult, but also rendered them very liable to lose their antiseptic properties in a very short time, even when properly prepared. Iodoform, as he says, is not so volatile, but his experience does not recommend it as a very efficient germicide.

Dr. Koch's experience with corrosive sublimate, which is non-volatile, caused him to turn his attention in this direction, and his results have been very satisfactory.

From the *British Medical Journal*, October 25, 1884, we learn that the dressings have been found to be often very irritating, sometimes they have caused symptoms of poisoning, while the histories of the cases ren-

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der it very doubtful whether in many instances a truly aseptic result has been obtained. We need not go over the experiments narrated in Sir Joseph Lister's paper, the result of which is very much as follows: He finds that sublimate combines with albumen to form not an albuminate properly speaking, but a simple mixture of the two, and that this mixture is much less irritating than a watery solution of corrosive sublimate; and serum which has been passed in small quantities through a gauze containing sublimate will not undergo decomposition, though inoculated with putrefying materials. A large amount of corrosive sublimate, however, must be present in the gauze, in order to obtain this result, more especially if blood, instead of serum, be used for the experiment. As the result of the discovery of the less irritating nature of the combination of albumen and sublimate, a sero-sublimate gauze has been prepared. This is easily made by soaking gauze in serum containing sublimate; for, though precipitate forms on first adding sublimate to albumen, this redissolves in excess of albumen. Sir Joseph Lister finds that a sero sublimate gauze containing 2 to 4 per cent. by weight of sublimate, is apparently non-irritating; while, at the same time, it is an effectual antiseptic dressing. Whether this gauze will supersede carbolic gauze, or whether objections may not be found to it, can only be determined as the result of more extended trial and investigation than that to which it has as yet been subjected. In any case, the sublimate cannot, as far as is at present evident, supersede carbolic acid for the purification of instruments, sponges, and the skin, or for the spray.—*Med. and Surg. Rep.*

Abdominal Surgery in Germany.—The following cases of interest were brought forward at the last German Congress of Surgeons, and afford good indications of the progress which this branch of surgery displays in Germany.

1. *Gastro-enterostomy for duodenal ulcer.*—The patient, who was twenty years old, had suffered from duodenal ulcer for four years. He was so reduced in strength that he weighed only fifty-one pounds. At one time he had vomited blood, but lately this had quite ceased, and he only suffered from vomiting of food. During the last few weeks, however, vomiting of blood had again appeared, and the bowels acted only after medicine. In these circumstances an operation was undertaken for the purpose of resecting the pylorus. When the stomach was exposed, it appeared that the narrowing was situated in the duodenum, and it seemed probable that prolonged treatment with the stomach-pump which had been attended with temporary success previously, might prevent the necessity of an operation, which even if performed successfully might be the seat of an ulcer at a later period. For a while the use of the stomach-pump was attended with success, but the patient very shortly returned,

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brought almost to death's door by a slight error in diet. As soon as he had been got into a suitable condition the operation was again undertaken. By raising up the left side of the great omentum and transverse colon the duodenum was reached. Resection was performed and the edges brought together with a double row of stitches behind, and a treble row in front. The wound was closed and the patient made an uninterruptedly good recovery. On the tenth day the bowels were opened naturally, after which time there were two motions daily without medicine. The patient was exhibited at the Congress.

2. *Resection of the small intestine for cancer.*—A tumor had been observed some four weeks by the patient. It was situated just above Poupart's ligament on the left side, but could not be certainly made out to be connected with the intestine. But the rapid emaciation and digestive trouble pointed to the conclusion that this was probably the case. About eight inches of intestine were excised by Dr. Schede, together with a wedge-shaped piece of mesentery, which contained some enlarged glands. The whole wound healed without further trouble, and in about three months the patient had regained flesh. About six months later he was seized with symptoms of intestinal obstruction, and was brought into the hospital in an almost dying condition. An artificial anus was at once made in the site of the old incision, and after introducing the finger a constricting band was found and divided, which at once relieved the patient. He had seven actions of the bowels the same day, but did perfectly well for four days, when he developed an attack of pleuro-pneumonia, from which he died. The post-mortem examination proved that the intestine had healed perfectly, and there was only a linear scar to show where the wound had been.

3. *Removal of the spleen for a cyst.*—The patient in question had his spleen removed in 1881, on account of a cyst about the size of a child's head. For the last two years he has followed his occupation as a mason. Immediately after the operation some changes were observable in the character of the blood, but these have since disappeared, and at the present time there is no enlargement of the thyroid or lymphatic glands.

4. *Removal of the spleen for sarcoma.*—A tumor of the spleen was displayed which had been removed a few months previously by Billroth. The patient was a woman aged forty-three who has been perfectly well since the operation. The patient had for ten years noticed an increased sense of resistance in the left hypochondriac region, which during the last two years had increased considerably and had become almost unbearable during the last few months, as it gave rise to intense dragging pains. A new growth in the spleen was diagnosed, and median laparotomy performed. The tumor was adherent behind to the tail of the pancreas,

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from which it was separated by the cautery. A portion of the pancreas came away attached to the tumor. The vein and artery were ligatured separately, and the rest of the gastro-splenic omentum in six pieces. After the operation the patient made an almost uninterruptedly good recovery, excepting only that she vomited a good deal for the first few days. For the first few weeks after the operation there was an increase to a slight extent in the white corpuscles; but there was no enlargement of the thyroid or lymphatic glands, or other troubles of any kind.

5. *A modified form of colotomy.*—Instead of performing the operation as it is usually done, Madelung cuts across the intestine completely and attaches the upper end to the opening in the side. By this means all the fæces pass at once by the side opening, and none can pass onward to irritate the rectal cancer. The lower part of the colon, which is in connection with the rectum, is closed at its upper end. The operation is of course not applicable in those cases in which the intestine is very full of fæces at the time of operation. In all other cases it is to be preferred. Amongst other advantages it is said to prevent prolapse of the intestine.—*Practitioner.*

Strangulated Hernia.—In the *Northwestern Lancet*, Dec. 15, '84, appears a report of a case of operation for strangulated inguinal hernia. After futile attempts to reduce by taxis, herniotomy was performed, and the constriction at the external ring being nicked, the hernia was reduced *en masse* into the abdominal cavity. The symptoms of strangulation being unrelieved, laparotomy was performed 24 hours later, and the sac being exposed, a very tight stricture was found within its neck. Peritonitis followed the operation, and resulted in death the next day. The operator is complimented by his colleagues for his candor in reporting the case. He criticises his own methods by laying the fatal result at the door of delay in performing laparotomy, but it is evident that neither he nor his colleagues see the hole in the millstone. We cannot imagine a case which more forcibly illustrates the deplorable results of surgical ignorance. In our estimation, the man who neglects opening the sac, in the light of our recent surgical teachings, is a very incompetent operator, and he who deliberately reduces a hernia *en masse*, assumes a responsibility fearful to contemplate. Here was a fine healthy young man of 18 years, sacrificed to surgical incompetence. The condition for operation was one of the most favorable possible. That herniotomy is an operation of great promise, is illustrated by Shrady's recent report of seven successful cases, several of which were as unfavorable for operation as could be imagined. If such be the results in hospital cases, in which strangulation has usually existed for some time, and in which the condition has been aggravated by prolonged and bungling efforts at reduction by taxis, the hospital being

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a dernier ressort, what ought we to expect from such cases as the one under consideration. As an example of professional candor, the case may be instructive, but the role of a terrible example would be far more fitting.

Treatment of Fractured Patella.—Dr. Van der Meulen notes that, in the space between the two fragments of a broken patella, a clot of blood is formed. This clot is not organized at once in its entirety, but the anterior and posterior surfaces are first organized, and only after some time does the process involve the central portion. In this way the two fragments come to be united by two thin pseudo membranes. The author takes advantage of this in his treatment of fractured patella. From ten to twenty days after the injury he proceeds to operate. An incision being made over the patella, the anterior membrane and the unorganized coagulum lying beneath it are removed, but the posterior membrane is not interfered with, and thus the joint is not opened. The fragments are then united by platinum or silver wire suture, care being taken not to include the membrane of organized coagulum, but to let it fold upon itself posteriorly toward the joint cavity. Dr. Van der Meulen has operated in this manner in three cases of fractured patella, and has been enabled to obtain excellent and firm union.—*Deutsche Med. Zeitung.—Pract.*

After-Treatment of Lithotomy, where the Bladder is Sacculated or Pouched.—Reginald Harrison calls attention to the risk of cystitis and septicæmia following lithotomy, when saccules or depressions exist, either in the walls of the bladder or upon its floor, behind an enlarged prostate. To remove a stone from such a saccule and not to provide for the free exit of urine and mucus from it, is, he maintains, bad surgery and apt to be followed by dangerous results. A saccule has no power of expelling its contents, and can consequently only be emptied by drainage. Its complete closure is facilitated by perpetuating the drainage for six to ten weeks. Drainage is accomplished by means of the ordinary lithotomy tube, through which a soft catheter is passed, The extremity of the catheter is passed well into the saccule which may exist. A long tube may be attached to the catheter, and the urine drained away as fast as formed, into a vessel under the bed. Frequent washing of the bladder with a saline solution is performed, and serves to free the bladder of salts and fermentable mucus.

The advantages of the double tube after lithotomy performed under the circumstances mentioned may be summarized as follows:

1. The prevention of vesical colic and spasm by retention of clots and the plugging of the ordinary tube with blood.

2. The more perfect drainage of the floor of the bladder, however irregular this surface may be.

3. A ready mode of washing out all parts of the bladder without re-

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moval of the outer tube. For the latter purpose, one of Tieman's double current rubber catheters, fitted onto a Higginson syringe and passed through the ordinary lithotomy tube answers admirably.

4. Increased facilities for keeping the patient dry, by the long tube extending under the bed.—*Lancet.*

Obstetrics and Gynecology.

Edited by E. P. MURDOCK, M.D., 130 S. Halsted St.

Treatment of Mastitis by Bandaging and Rest.—The use of very gentle friction with oil, the withdrawal of milk in sufficient quantities to relieve distention of the glands, belladonna plaster, cold applications, hot fomentations, supporting the breast in a sling, abstinence from fluid and liquid food, saline laxitives, iodide of potassium, ergot, quinine, ect., have long been considered measures more or less important in the treatment of this painfully wearying affection. In early practice Harris had the misfortune to meet with many cases of suppurative inflammation of this gland, and in 1876 changed his mode of treating this affection, and has had very different and most satisfactory results from the new mode of procedure. He observes that after careful investigation into the habits of the domestic brute creation, particularly the cat, bitch, mare, cow and ewe, that though frequently deprived of their young while the secretory function of the mammary gland is at its height, yet they are comparatively exempt from the occurrence of mammary abscess, and that such as do occcur are principally with the cow and horse after meddlesome manipulative interference by the over-zealous owner, while the cat, dog, ewe and others being deprived of their young and left without care save being permitted to have complete rest, recover without much trouble. Thus he concludes that rest and non-interference, as a means favoring a speedy recovery from mammary troubles in certain animals, applies with equal if not greater force to the human female.

As a means of securing rest Harris elaborates his plan and accompanies his explanation with half a dozen good cuts showing the use of the bandage as a measure calculated to secure complete rest for the gland, rest from passive motion, rest from secretion, and rest from pain. He procures a roll of soft cotton wool (cotton batting) or surgeons' absorbent cotton, a plain roller bandage 20 yards long and 2 or 2¼ inches wide, also 18 large safety pins. The room being warm he assists the patient into a sitting posture, and in the partial removal of her garments by withdrawing the arms, allows the clothing to fall about her waist. Then assuming the left breast to be the one inflamed he passes the roller under the left breast

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and over the right shoulder, first having carefully padded the points named with the cotton, and so continue until the breast is completely and firmly supported; then pass the bandage several times around the waist below the breast to secure it; this he calls half bandaging. If it is considered desirable to bandage the entire breast, as it usually is, he then passes the bandage under the right breast and over the left shoulder—padding as before, and follows this with a number of horizontal turns above the breast and over the pectorid muscles, finally covering the affected breast, completely including the nipple, but leaving the nipple—and that only—of the unaffected breast exposed for the child to nurse. This bandage should be removed and reapplied daily: the effect will be quite unsatisfactory for about three days, and excite some fears, after which the inflammation will rapidly subside, and the final results pleasing in the highest degree.

Added to this detailed account of his method Harris gives the histories of sixteen cases in which but one progressed to suppuration, and that seemed to be largely the fault of the patient. The showing is certainly a very favorable one for this condition everybody dreads, and but few authors venture to discuss.—*P. A. Harris, M.D., in Am. Jour. Obst.*, January, 1885.

Hazeline in Menorrhagia.—In the *Practitioner* Mr. M. Cherte describes a valuable remedy for menorrhagia, which is a very frequent ailment in women of Cape Colony. Two drachms of hazeline given twice or thrice daily will act so quickly that it will not be necessary to anticipate the flow, but when menstruation, after it has lasted the ordinary time, is not closing naturally, hazeline given as above will effectually restrain it. After hemorrhage has ceased there will be no advantage in continuing the drug. Another good result from hazeline is relief from pain in dysmenorrhea in a very quick and marked manner.—*Med. and Surg. Rept.*

Uterine Mole.—Prof. A. M. Owen presented me with a fleshy oval mass larger than a hen's egg, and similarly shaped with the following history: It came from a lady 29 years of age, who was the mother of three children, the youngest 4 years old. She suffered an attack of measles in May last, at which time she had a discharge from the uterus, that she supposed to be catamenial. After this period she had suppression of the menses, with enlargement of the abdomen, and supposed herself pregnant for several months. After this the abdomen ceased to enlarge, and became flattened. In January, 1885, she had a sanguineous discharge from the uterus, which she supposed to be a return of the menses, and in February, after some uterine pains, the body referred to above was expelled. The surface of the fleshy ball was somewhat flattened, red and granulated on one side, showing that at this part it had

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been attached to the uterine wall. The opposite surface was more convex, and covered by a smooth but ragged membrane. On opening the mass it revealed a cavity, and this also was lined by a shining membrane, and contained clotted blood. The whole mass appeared to be granular and not fibrous. It was not examined by the microscope. I judged the body to consist of a degenerated placenta, supposing that the attack of measles brought on a partial abortion in early pregnancy, and that the placenta did not come away, but continued its attachment to the uterine surface, and thus received nourishment, sufficient to maintain its vitality, and to a small degree its growth. By degrees the uterus ceased to enlarge, and by contracting upon the mass, its edges were gradually folded up or crowded together, until when brought in contact they adhered, thus changing the flat placenta into an egg-shaped mole. If this explanation of its genesis be correct, it reveals one important fact, namely, that in abortions the placenta may sometimes be retained for months without undergoing decomposition, and consequently without causing septicemia; showing, also, that it may be unwise to resort to violent measures to remove the placenta, in cases of partial abortion, when if left to the recuperative powers of nature, they may come away without subjecting the patient to any serious damage.—*G. B. Walker, M.D., Evansville, Ind.*

Cold Applications in Labor.—Dr. Grognot (*Bull. Gen. de Therap.*) recommends the use of cold to increase labor pains. It is well known that to palpate the abdomen in a pregnant woman, the hands must be of approximately the same temperature with that of the skin of the patient; otherwise if too cold the disagreeable sensation will produce immediate contraction of the muscular walls of the abdomen, and prevent a proper examination. But if persisted in this may extend to the uterus itself, and give the sensation of the presence of a regular globular tumor, contracting not from the pressure but from the effects of the cold.

Dr. Grognot uses a bucket of fresh water, into which—when it is deemed desirable to provoke pains—he places his hands for one or two minutes, and then applies them to the abdomen, and as fully as possible over the region which covers the anterior superior surface of the uterus. In a few seconds the patient complains of a pain and then the hands are removed. It is generally not necessary to use this method more than ten or fifteen minutes. The following are his conclusions: 1st. Application of cold provokes marked contractions during labor; 2d, they are normal in their effects; 3rd, this method is without danger to mother or child; 4th, it can be used independently and without instruments; 5th, it can be employed during any or all stages of labor, for the expulsion of the fœtus or placenta.—*Jour. Am. Med. Association.*

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Eye and Ear.

Edited by J. E. HARPER, M.D., 163 State St.

Ear Piercing; Death. — From Paris comes report of a case of a child's ear being pierced through the cartilaginous portion instead of the lobe. A pair of gold ear-rings were inserted; one hour later the ear, then the neck, became swollen; that night death took place.— *W. D. Babcock, M.D., Evansville, Ind.*

Perforation of Mastoid Cells.—When Dr. Dalby, in a paper read before the Royal Med. and Chir. Society, Jan. 27, 1885, held that whenever the constitutional symptoms pointed to pus in the mastoid cells, even if the external plate was healthy, the cells should be perforated, he expressed the belief that perforation of the mastoid cells was more urgently and frequently required than the literature of the present day would lead the reader to infer.— *W. D. B.*

Drainage in Otorrhœa.—Dr. C. Atkin, before the Sheffield Medical Society, England, thought that the importance of keeping the eustachian tube pervious in cases of otorrhœa was not fully appreciated. He had noted in several fatal cases that the eustachian tube was blocked with inspissated secretions. He read the notes of one fatal case where the pus had not burrowed back to the mastoid cells, but had ulcerated through into the roof of the pharynx, causing an intermittent fœtid discharge. The writer would add a similar case to the above; the discharge was into mouth, between tonsil and angle of the lower jaw. He always uses politzeration in all cases of otorrhœa, and is not satisfied until the tube is fully pervious.— *W. D. B.*

Corneal Suppuraton after Cataract Operations.—Dr. J. R. Wolf, of Glasgow, Scotland, at the last meeting of the British Medical Association, claimed that the position of the section in cataract operations has no influence upon suppuration of the cornea, and that antisepticism when applied to the eye is altogether out of place, another scape-goat for defective methods, when the lids are closed the eye is placed in a shut cavity which is inaccessible to septic agents. He thinks we must seek elsewhere for the cause, namely, in the deeper structures.— *W. D. B.*

Astigmatism Cause of Sick Headache.—Dr. Hewetson presented to the Leeds Medical Society six cases of migrane whose attacks had been cured completely by wearing proper correcting cylinders. Between the attacks of several there had been chronic dyspepsia and vertigo.— *Brit. Med. Jour.*, Jan. 3, '85.

Exophthalmic Goitre.—In the Birmingham, Eng., General Hospital,

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three cases of goitre have been under observation, all married women, aged 21, 34 and 41. Treatment unsatisfactory, constant current did no good. Small doses bromide potash with citrate iron and ammon. seemed to do most good.—*W. D. B.*

Pannus.—Dr. David Webster, of New York City, recommends an infusion of one jequirity bean to one ounce of water. One application to inverted lid daily until inflammation sets up. Bathe lids with infusion for half an hour after application. If symptoms are not severe bathe the eyes with hot water. If great pain and swelling, apply iced cloths and atropine. One application every month or two if improvement seems to stop.—*W. D. B.*

Pediatrics.

Edited by MARCUS P. HATFIELD, M.D., 3446 Wabash Ave.

Fatty Diarrhœa in Children.—In a paper on fatty diarrhœa of children, as understood by Demme and Biedert, Ischernov has found, from an examintion as to the amount of fat contained in the fæces of healthy and fevered adults and children, that in fever at least 14 per cent. of the fatty food is absorbed. He then made analysis of the fæces of children under six years of age, and under different circumstances.

In the fæces of seven healthy children he found from 25 to 30 per cent. of fat; in that of two prematurely born children 47 to 57 per cent.; in four children with dyspepsia, 37.6 per cent., (normal state, 26.3) 43.6 (normal 27), 43.5 (in this case the mother's milk contained only 1.5 per cent. of fat), and 62.2; examinations were also made in fourteen other cases, in which the children suffered from different diseases, and in whom there were symptoms of intestinal irritation.

In a case of erysipelas the fat amounted to 52.2 per cent.; catarrhal pneumonia, 51.1 per cent. (during convalescence, 42 per cent.), 51.7, (convalescence, 33.1) and 60.9 (convalescence, 55.2); in a case of large abscess, 67 per cent. of fat, which fell to 48.3 when the abscess was opened and improvement began. In a case of icterus, with enlargement of the liver and spleen and severe diarrhœa, there was 75.3 per cent. of fat.

Ischernov concludes there is no such a disease as fatty diarrhœa, but that it is a symptom found in various and widely different diseases.—*Centralbl. für Klin. Med.*, Sept. 27, 1884; *Med. News*, Nov. 22, 1884.

Oxyurides, or Ascarides Vermiculares, their Habitat and Treatment.—Under the above heading a writer in the *Medical Record* of Jan. 31, 1885, gives a two-column article, in which he says the rectum has not the exclusive right to the claim made for it by most writers on pediatrics,

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as the home of the ascaris oxyuris, and quotes Kuchenmeister as saying in support of his theory, that they inhabit the large intestinal, especially the cæcum and rectum.

Cobbold says: "It is an error to suppose that the lower bowel or rectum forms their especial habitat, nevertheless the most approved manuals, *vade mecums*, and general treatises, have for a long time supported this general view." And according to the same author, "they commonly infest the terminal portions of the intestinal tube, being especially abundant in the sigmoid flexure of the colon."

He also quotes Leuckart as saying: "Their only natural abode is the large intestine, the whole length of which is often inhabited." "They are also found in the cæcum and small intestine."

The writer then cites two cases which occurred in his private practice, peculiar for their obstinacy, and one especially peculiar in this respect, occurring in a young lady seventeen years old. She had been troubled since infancy by ascarides, with intervals of comparative freedom. The patient had a rectal abscess, resulting in a fistula. The rectal abscesses, the writer believed to be due to the ascarides. Yet he leaves out of the count the injections of nitrate of silver, strong infusions of the seeds of chenopodium, etc., which might play an important role in the etiology of the rectal abscesses. One thing that seemed of especial interest to the writer, was the fact that while making a rectal examination a quantity of jelly-like mucus, containing a few oxyurides, oozed from the sigmoid flexure of the colon.

Which is the Better Evidence?—For the following we are indebted to the *Medical Age:* "It is only the practitioner whose experience is limited, who makes light of the difficulty of making a differential diagnosis of small-pox, in the early stages of the disease. This difficulty is so great, especially when the patient bears marks of successful vaccination, as to require time to overcome it. A professional gentleman in this city professes to be able to distinguish between the two diseases (variola and varicella), even when the eruption is in the papular stage, by his sense of smell. Doubtless this sense exists in a degree of extreme acuteness in some men, as we know for a certainty it does in some animals; but for the practitioner of the average nose, this method of making a differential diagnosis can never be of value. This inability to promptly decide between the existence of a trifling affection and a grave disease, is not calculated to elevate the profession in popular esteem. Any point, therefore, which will assist in removing this opprobrium medicorum will be warmly welcomed. We have one given us by Dr. C. Bareggi (*Centralb. für Klin. Med*). He withdraws the fluid—the fluid contents of variolous papules and pustules, and having made dry preparations of them, in the

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usual way, stains them with methylene blue. Under the microscope they exhibit large numbers of cocci described by Klebs as characteristic of variola. The author could discover none of these cocci in pus withdrawn from any other source, thus establishing the non-identity of variola and varicella."

Knee-Jerk in Diabetes.—The introduction of one new condition into any existing arrangement cannot take place without producing more than one alteration. The phenomenon of the knee-jerk which may practically be said to have been introduced into the sphere of clinical medicine during the past decade bears testimony to the above generalization. The investigation of the condition of the knee-jerk may seem to some medical men a somewhat novel application of a reflex action. M. Bouchard made a distinct impression by his paper on the subject at the French Association for the Advancement of Science recently held at Blois. The presence or absence of the knee phenomenon in diabetes mellitus is said to possess much importance both from a prognostic and diagnostic point of view. Forty-seven cases observed during the last three years by M. Bouchard were found to have the patellar-tendon reflex, and of these cases only two died, or about 4 per cent. Nineteen cases were collected in which the knee-jerk was absent, and of these six were fatal, or about 33 per cent.; the mortality in the latter group may have been still greater, since some of the number were lost sight of. The members of the second category also had a cachectic aspect. M. Bouchard believes that the disappearance of the knee phenomenon in the course of diabetes indicates the entry into a grave and perilous state. It is perhaps lending too much value to the knee-jerk to say that the absence of it has given the cue to the diagnosis of diabetic coma; a statement to this effect may be found in the report from which we abstract our information on M. Bouchard's paper. An infant was found comatose with dry cracked lips and absolutely afebrlle; none of its antecedents could be ascertained. The knee-jerk was absent and the coma resembled that met with in cases of intoxication, and of uræmic or diabetic toxæmia. There was the odor of acetone in the breath; some balano-posthitis and intense thirst. A washing from the child's underlinen reduced Fehling's solution. M. Bouchard thinks it necessary to state that the absence of the "tendon reflex" does not favor the nervous theory of diabetes.

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Books.

SURGICAL HANDICRAFT: A Manual of Surgical Manipulations, Minor Surgery and Surgical Dressings. By Walter Pye, F. R. S. C. S., Eng. Henry Kimpton, Publisher, 82 High Holborn, London.

We are pleased to greet this new work upon surgical dressings, the more especially as it is the most comprehensive work of the kind with which we are acquainted. Most of the manuals devoted to the subject are sadly lacking in breadth of scope, and completeness, and we needed something of the character of Mr. Pye's "Handicraft." The marvel is not that he has found material for a work of nearly 600 pages upon surgical appliances, but that he has succeeded in covering so much within these limits. The arrangement of the work is excellent, the marginal index being especially commendable. The style is concise, and as a text book the work will doubtless displace many of the smaller works at present in use. The illustrations are very numerous, a by no means unimportant point in favor of the book, and better still, they are intelligible, which is not to be said of those present in some of the older works upon surgical dressings. An excellent chapter upon anæsthetics is presented by Mr. Joseph Mills, administrator to St. Bartholomew's Hospital. The work is designed especially for the use of hospital, house surgeons and dressers, but we are certain that the general practitioner and surgeon in extensive practice cannot fail to appreciate its value. As the American agency is in the hands of Messrs. P. Blakiston & Sons, of Philadelphia, we have little doubt that Pye's Surgical Handicraft will find its way to the hands of many of our American surgeons. G. F. L.

THE HAIR: Its Growth, Care, Diseases and Treatment.—By C. Henri Leonard, M.A., M.D., Professor of Medical and Surgical Diseases of Women, and Clinical Gynecology, in the Michigan College of Medicine; member American Medical Association, etc.

This is a neat little work of over 300 pages, full of information useful to both the profession and laity, and beautifully illustrated with one hundred and sixteen engravings. It is intended as an introduction to a larger and more scientific work which the author expects to have ready for publication in the near future. H. J. R.

STUDENT'S MANUAL OF ELECTRO-THERAPEUTICS, embodying Lectures Delivered in the Course on Therapeutics at the Woman's Medical College of the New York Infirmary.—By R. W. Amidon, A.M., M.D.

This compendious work contains a brief and clear explanation of the construction and use of medical batteries, points out the most frequent and conspicuous physiological effects of electricity, indicates the methods of electro-diagnosis, and lastly, determines the kind of electricity and its mode of application indicated in different affections. It is, undoubtedly, a most valuable little book for the student and busy practitioner.

C. C. P. S.

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RESOLUTIONS ADOPTED BY THE JUNIOR CLASS OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF CHICAGO, UPON THE DEATH OF LUDWIG HELLER.

WHEREAS, In view of the loss we have sustained by the decease of our friend and associate, Ludwig Heller, and of the still heavier loss sustained by those who were nearest and dearest to him; therefore be it

Resolved, That it is but a just tribute to the memory of the departed to say that in regretting his removal from our midst we mourn for one who was in every way worthy of our respect and regard.

Resolved, That we sincerely condole with the family and friends of the deceased on the dispensation of Divine Providence to afflict them, and commend them for consolation to Him who orders all things for the best, and whose chastisements are meant in mercy.

Resolved, That this heartfelt testimonial of our sympathy and sorrow be forwarded to the friends of our departed classmate by the secretary of the class, and be printed in the WESTERN MEDICAL REPORTER.

Signed, G. S. LOOP, S. H. NEWTON, E. N. FLINT, } *Committee.*

Obituary.—Dr. Thomas N. Reynolds, of Detroit, Mich., one of the leading physicians of that city, died in San Antonia, Texas, on Saturday, 14th inst. He was born in Picton, Ont., Feb. 2, 1843. He received his literary education in Medford, Owen Sound and Toronto, Ont., and in 1870 graduated from the Toronto School of Medicine, and the College of Physicians and Surgeons of Ontario, with honors. He then commenced practice at Orion, Mich., where he soon became known as one of the leading physicians of that portion of the State. In 1875 he retired from practice and went to Europe, where he made an extensive tour through England, Ireland and Scotland, Austria, Prussia, Italy, France and Spain; devoting special attention to medical pursuits in the leading hospitals of London, Edinburg, Berlin, Vienna and Paris. In 1877 he returned and settled in Detroit, where he soon became very actively engaged in practice. In 1883, from over-work and exposure he contracted a bronchitis, from which he never recovered, and in the spring of 1884 he gave up practice, since which time he had traveled most of the time for his health. His life, though his health was much impaired by the lung trouble, was finally brought to a close by a severe hemorrhage from the lungs.

He was Professor of Materia Medica and Therapeutics and of Clinical medicine in the Detroit Medical College, physician to St. Mary's Hospital, member of the North Eastern District Medical Association, member of the Detroit Medical and Library Association, of the Michigan State Medical Society, and of the American Medical Association.

He was also an honorary member of the Ancient Order of Forresters, and a Knight Templar; by the latter of which orders his burial services were conducted. He leaves two brothers in the profession, both of this city, Dr. Henry J. Reynolds, Professor of Dermatology in the College of Physicians and Surgeons, and one of the editors of this journal; and Dr. Arthur R. Reynolds, one of the physicians to the West Side Dispensary, both of whom will feel the loss deeply. J. E. H.

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THE WESTERN
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Medicine.

Edited by WM. E. QUINE, M.D., 3151 Wabash Ave.

The Diagnostic Differences Between Bronchitis and Heart-Disease.—Although the clinical features of bronchitis and heart-disease are sufficiently distinctive to be at once recognized by the experienced medical man, apart from a physical examination of the chest, and although the post-mortem appearances in the two diseases are also markedly different, yet it is not at once apparent why, when both show congestion of the lungs, as the main symptom or immediate cause of death, they should present such distinctive peculiarities. It is important not only to recognize these differences, but to set clearly before ourselves their causes; since, in complicated cases, this will lead to a correct diagnosis, and suggest the appropriate treatment. In a simple case of severe bronchitis, the patient is seen sitting up in bed, and breathing with difficulty; that is, he is using all the muscular effort he can to draw air into the chest, having, indeed, true dyspnœa. At the same time his face is blue, and his extremities livid. The chest is resonant on percussion, the abdomen is not enlarged, and there is no dropsy. In the heart case, notably when the mitral valve is diseased, the patient has not dyspnœa, but apnœa; he can easily fill his chest with air, but, owing to the impeded and irregular circulation, he experiences the distress known as cardiac apnœa or breathlessness. His skin may be pale or yellow at the upper part of the body; the chest may be dull at its lower part, especially on the right side; the abdomen may be full, the liver enlarged; there may be dropsy of the legs, and some albumen in the urine. In the first case, in spite of the lividity of the skin, the congestion, as seen by its effects on the organs, is not nearly so great as in the second, or cardiac case. I take the case of

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mitral disease, for in aortic, when the blood is thrown back on the heart, the body is pale and impoverished, and it is not until the mitral valve gives way that the congestive conditions become apparent.

Let us see why these differences exist. In the case of bronchitis, the blood is impeded in the pulmonary artery, as is evidenced by the hypertrophy of the right ventricle, and, subsequently, an engorgement takes place in the general venous system. The forces which urge the blood through the lung are in part mechanical and in part chemical. If the air be prevented from entering the trachea from any obstruction, the blood is hindered in its passage through the alveoli, showing that the chemical process of aeration is necessary for the natural flow of the blood. In cases of strangulation, therefore, the right side of the heart is distended, and the whole venous system gorged. If the obstruction be slower or more partial, as in ordinary diseases of the air-passages, the right ventricle, after a time, forces the imperfectly aerated blood through the lungs; and, there being nothing to impede its flow onward in the pulmonary vein or left ventricle, it takes its course through the system. In this way, the pulmonary circulation is freed, and the lividity of the countenance in bronchitis is therefore not so much owing to venous stasis, as to the presence of dark blood circulating in the arteries. This is the only explanation which I can see to account for the slight engorgement of the various organs in bronchial affections. Take, now, the case of mitral disease; the blood is thrown back on the pulmonary veins, and this arrests the flow coming from the right side of the heart through the pulmonary artery; consequently, the whole of the capillary system of the lungs is gorged on both sides of the termination of the bronchi. You will see that there is no longer a question of the possibility of non-aerated blood passing the alveoli of the lung, since there is a positive mechanical hindrance to the passage of any fluid. The congestion of the lung in the two cases is, therefore, of a very different kind; in the bronchitis, it is on one side of the alveoli only; in the heart-case, it is on both sides; in the former, it is in the pulmonary artery; in the latter, in both pulmonary vein and artery commencing in the vein; consequently, the effects are very different on the several organs, and on the body at large.

In the case of bronchitis, although the patient is livid, the congestion does not attain the intensity it does in that of the heart. Here the blood may actually stagnate in the vessels, producing a consolidation of the lung, or may burst through the tissues, so as to constitute a pulmonary apoplexy. This is known during life by hæmoptysis, and the dullness and absence of breath-sounds on percussion and auscultation. In the same way, and for the same reason, the liver becomes altered, as it rarely is in bronchitis, until the congestion produces great enlargement and the

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condition known as nutmeg-liver; the kidneys, also, from like engorgement, may show albumen in the urine, and the legs become dropsical. After death, the effects of the engorgement are seen in the indurated lung, spleen, enlarged kidney, and nutmeg-liver. These altered states of organs are so well marked, that their appearance alone would denote death from heart-disease. I have frequently been asked why the same conditions do not obtain in bronchitis. I have now endeavored to give the explanation.

I have brought the subject especially before you in connection with the numerous cases we have in the hospital, on account of the important practical consequences which result from a knowledge of it. Many cases are not so simple as I have described. A patient, for example, may be found sitting up in bed, breathing with difficulty, and with so much rattling in the chest as to preclude the possibility of rightly gauging the state of the heart. If the case be one of primary bronchitis, this is the disease to treat; if the heart be at fault, that may be the organ to administer to, and the secretion in the tubes be allowed to go on as a salutary process of relief. Suppose, in such a case, the liver be found enlarged, this fact would point to the heart as being the principal cause of the symptoms, and you would prescribe accordingly. Or we might, as we often do, meet with a much more complex case, where, besides the symptoms just named, the urine is albuminous, and the patient dropsical. It is much more easy to call such a case one of renal dropsy, as I have often heard done, than to make out accurately the true causation of the different morbid processes. If, however, on careful examination, we find the liver enlarged and the lung gorged, it is much more likely to be one of heart-disease, and the albuminous urine a secondary affection. Let the case be treated on this supposition, and we may often see the dropsy disappear, the urine become healthy, the liver decrease, the engorgement of lung pass off, and the patient resume his usual condition—one of chronically impaired heart. Such instances are far from common; for I constantly see cases regarded as primary bronchitis, others as primary liver-disease owing to its enlargement, others as Bright's disease owing to the presence of albumen in the urine, and yet all these conditions are due to congestions arising from heart-disease. This has been overlooked, owing to the absence of bruits, or their obscuration by pulmonary sounds. It is, therefore, most important to take note of other facts and considerations on which to found a diagnosis.

I could point to numerous cases where digitalis and other appropriate remedies have been given to quiet and strengthen the central organ of the circulation, and all the other ailments have departed. I cannot, therefore, too much impress upon you the value of a diagnosis in these cases;

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and consider well all the points to which I have drawn your attention, for upon your due appreciation of them the life of your patient may depend. I have necessarily taken typical cases to dwell upon, and have drawn from a large general experience; at the same time, I should say that there are exceptional cases, which would require further explanation, such as the rarer instances of bronchitis associated with enlargement of the liver and dropsy.—*Samuel Wilks, M.D., Physician to Guy's Hospital, in British Med. Jour.*

Charcot's Disease.*—In his speech at the Clinical Society Dr. Moxon said that he "would be very thankful to any member who would explain in what possible way herpes zoster threw any light on this so-called 'Charcot's disease.'" It is not difficult to establish a fair analogy be- the two affections. Charcot himself refers to a case at the Hotel Dieu, related by M. Ball, which was accompanied by pain, febrile reaction, and zona, and observes: "This complication is well calculated to demonstrate at least the neuropathic, if not the spinal, origin of the affection." The neuralgic pains often attending herpes zoster may be compared with the lightning pains which inaugurate tabes dorsalis, and which most commonly constitute the only symptom when the arthropathy is developed. The effusion into vesicles, though more distinctly of an inflammatory character, has its counterpart in the engorgement and œdema of limbs, and the hydrarthroses of joints, which are among the earliest local indications of Charcot's disease. Even the definite course and complete disappearance which are ordinarily exhibited in zona may be imitated in "Charcot's disease." "At the end of some weeks or of some months the swelling disappears, and then all returns to the normal state" in the *benignant form* of the affection. "Sometimes, on the contrary, serious disorders remain in the joints, crackings, dislocations, answering to a wearing down of the osseous surfaces and various luxations (malignant form)." These phenomena, as Dr. Broadbent pointed out, are comparable with the destructive ulcerations of skin which may be caused by herpes zoster, and the disorganization of an eyeball which may be the result of herpes following the course of the fifth cranial nerve.

The two main factors, both in herpes zoster and Charcot's disease, may be said to be irritation of sensory nerves and trophic lesions. The same factors are present in other affections of bones of which the pathology is obscure, and strongly point to a mediate or immediate influence exercised by the central nervous system. Mollities ossium is preceded and accompanied by general weakness, profuse perspirations, and violent

* This communication contains the substance of what I had intended to say at the Clinical Society on the last night of the debate on Charcot's disease. Owing to the lateness of the hour at the time when the President's list of speakers became exhausted, I abstained from addressing the Society, for fear of interfering with Mr. Baker's reply.

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and persistent pains in the bones or all over the body. In all cases known to Mr. Durham, some influence had been at work capable of producing great general depression of the nervous system. Even in rickets a preliminary or attendant disorder of the nervous system is shown by restlessness, perspirations, and great tenderness of surface. Again, in cases related by Mr. Stanley under the title of fragilitas ossium, cases which differ from mollities in the presence of simple thinning of the walls of the bones without softening or morbid deposit, fractures arising from very slight causes were preceded by pains in the bones, or by what was termed "rheumatism" of the limbs. Is it possible that any of these cases, although occurring in women between twenty or thirty, may have been instances either of commencing tabes not then recognized or of some kindred lesion of the nervous system not yet elucidated? The fractures related by Mr. Stanley were accompanied by very little pain at the seat of the injury. In one case several fractures occurred in succession, and no union was obtained after treatment for two years.

The likeness existing between these several affections, tabetic arthropathy and tabetic fractures, mollities ossium and fragilitas ossium, and the analogy which can be drawn between Charcot's disease and herpes zoster as regards the primary disturbance of sensibility and the trophic lesions which follow in direct succession, indicate active intervention of nervous agency, and give support to the view that tabetic arthropathy is of neuropathic origin. Opposed to this rational explanation is the rather fanciful supposition that Charcot's disease is merely arthritis deformans accidentally occurring in the course of tabes, and somewhat altered from its pattern by the intervention of the nervous disease. It is urged in support of this hypothesis that whilst in typical specimens of each affection the differences between them are very startling, if a large range of specimens is taken the one affection runs into the other. Moreover, Mr. Hulke pointed out that in one individual, whilst the elbow-joints showed a predominance of tabetic characters, the knee-joint showed a predominance of characters typical of chronic rheumatic arthritis, viz., expansions and stalactitic outgrowths. In reply to this view I would submit:—

1. That puzzling intermediate forms do not prove the identity of the typical forms thus connected, but only a certain relationship, the precise nature of which has yet to be ascertained. Nowhere in nature can either groups of living beings or pathological lesions be found which do not blend with their neighbors. The existence of intermediate forms renders it impossible to frame scientific definitions which shall fulfil logical requirements. There is always an amphioxus. Lupus is an affection which has very distinctive characters, and is usually very little likely to be mistaken for psoriasis, acne, or eczema; yet there are forms of the disease which so

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trench on the characters of the other affections mentioned that the terms "lupus psoriasis," "lupus acne," and "lupus eczema" have been coined to describe them. Carcinoma and sarcoma, closely as they are allied, have distinctive features, but to confound their definitions there occurs an intermediate form, alveolar sarcoma, for which Mr. Butlin is obliged to assure his readers that he is not responsible.

2. It is not permissible from the occasional resemblance and intermingling of specimens of tabetic arthropathy and arthritis deformans to argue that Charcot's joint disease does not result from some central or local nerve lesion occurring in the course of tabes, until it has been clearly shown that the belief in the neuropathic origin of arthritis deformans entertained by many is unfounded. Until this is done demonstrations of affinity rather tend to support the neuropathic origin of arthritis deformans.

3. In comparing arthritis deformans with Charcot's disease regard must chiefly be paid, as Charcot points out, to the predominant characters of the lesions. Charcot admits that "it is not rare to see nodose rheumatism, common dry arthritis, coincide with ataxia," and no one in the debate described the occasional coincidences between dry arthritis and tabetic arthropathy in terms half so forcible and unreserved as those employed by Charcot himself. "Undoubtedly," he says, in his lectures "in cases of old standing, when the articular surfaces, worn and deprived of cartilage, have continued to move on each other, the limbs being still made use of more or less imperfectly, the signs observed are those of dry arthritis—viz., eburnation, deformation of the osseous extremities, bony burrs, stalactites, and foreign bodies." Herein, very likely, lies the explanation of Mr. Hulke's observation; the affection of the knee-joint which displayed the arthritic peculiarities being of longer standing than the affection of the elbow-joint in which wearing away of bone was the main feature. On the other hand, Charcot insists that when dry arthritis occurs in the course of tabes it exhibits its accustomed symptoms, that in tabetic arthropathy there is always a predominance of wearing away over the production of bony burrs in recent cases, and that true luxations are frequent in tabes, and exceptional or only apparent and not real in common dry arthritis. The intersticial absorption which occurs in arthritis deformans along the line of pressure is always accompanied by compensatory condensation and marginal hyperplasia, characters entirely absent in the specimens exhibited at the International Medical Congress held in London in 1881. These specimens were so typical that Sir James Paget drew M. Charcot's attention to the fact that tabetic arthropathy was a new disease, and the writer of the *Museum Report*, following suit, affirmed that it was a "distinct pathological entity." I think it is worth

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while also to point out that, whilst Dr. Moxon contends that a continuance of friction would convert a specimen of arthritis deformans in an excabman into a tabetic arthropathy, Charcot explains that old specimens of tabetic arthropathy assume from friction the characters of arthritis deformans.

4. If tabes dorsalis is admitted to be capable of so altering a typical example of arthritis deformans, with its attendant eburnation, marginal hyperplasia additamentary bones, hypertrophied synovial fringes, foreign bodies, increased density of bone, thickened capsules and ligaments, and stiffened, painful joint into a typical example of atrophied worn bones of diminished density, with no inflammatory changes other than rarefaction, with flail-like and luxated joints accompanied, it may be, with spontaneous fractures, or to be capable of preventing the exhibition of the typical characters of arthritis deformans, this is tantamount to admitting in a roundabout way a casual relationship between the nervous lesion of tabes and tabetic arthropathy. Such an admission must necessarily end in an unreserved acceptance of the simpler view of the occurrence of Charcot's disease as the direct effect of tabes without the intervention of arthritis deformans.

5. Tabetic arthropathies have special clinical characteristics and accompaniments which mark them off from arthritis deformans. These are the occurrence of the joint lesions at a particular and comparatively early stage of tabes—viz., after the prodromal stage and before the onset of ataxic symptoms—a special sequence of the joint affections, the lower limbs suffering before the upper, rapid destruction of joints without pain or fever, rapid luxations, and equally sudden and spontaneous fractures Four examples of fractures from slight causes in association with tabetic symptoms have occurred in my practice at the London Hospital, and these I will take an early opportunity to bring before the Clinical Society. In one a lesion of the knee-joint was associated with a "spontaneous" fracture of the tibia and fibula about three inches below the affected articulation. Fractures of this kind do not occur in connection with arthritis deformans, and though scarcely referred to in the course of the debate supply one of the strongest arguments in favor of the tabetic nature of Charcot's disease.

Since the knowledge of tabetic arthropathy became current knowledge, I have not unquestionably, to use Charcot's language, "assisted at the development of an ataxic arthropathy" in addition to the case above referred to; but in the pretabetic times I have met with one or two cases of swollen, crackling, flail-like joints, occurring suddenly in middle-aged individuals, which were diagnosed as chronic rheumatic arthritis, but which in all probability, preceded as they were by so-called "rheumatic"

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pains in the limbs, were typical examples of Charcot's disease. This unavoidable confusion, occurring doubtless to bygone as well as to existing observers, still casts its shadow across the path that leads to the recognition of Charcot's disease as a genuine tabetic lesion; and it may be necessary to defer a final judgment on the questions raised in the debate until further observations have been made in this country; and until the advance of physiology and pathology has dispersed the mists which still becloud the relations of the nervous system to the bones and joints in health and in disease. — *Walter Rivington, M.S., Lond., F.R.C.S., Eng., Surgeon to the London Hospital, in The Lancet.*

Chorea, Treated with Continuous Inhalation of Chloroform: Recovery. —Dr. Bostock said that the patient, a young girl, was admitted into one of Dr. Davidson's wards, with a very severe attack of chorea. She had suffered from no previous illness, but there was a well marked history of fright. Up to the sixth day, she was treated in the ordinary way with conium, chloral, bromide of potassium, etc.; but became progressively worse. She could now be scarcely restrained, and the skin was already beginning to give way. Chloroform was therefore given to produce sleep, and a very little had the desired effect; it was therefore repeated when necessary. This was continued for eight days; but, as soon as she was allowed to come round thoroughly, she was as violent as ever; the chloroform was therefore given continuously for forty-eight hours, at the end of which time, the movements being much more easily restrained, the limbs were wrapped in cotton-wool, and firmly bandaged to the bed. This seemed to be of great service to her; and, from this time, she gradually improved, and ultimately made a rapid and complete recovery. Drs. Greeves, J. Cameron, and Carter all spoke favorably of the use of chloroform in bad cases of chorea; Dr. Greeves also recommending Calabar bean, and Dr. Carter strychnia. Dr. W. Williams had found marked relief follow the use of the ether-spray to the spine. Dr. Archer objected to any restraint of the muscular movements.—*Brit. Med. Jour.*

Lead-Poisoning by Snuff.—Dr. Weaver (Frodsham) read notes of the case of a solicitor who was attacked with colic, and subsequently with wrist-drop. He was a great snuff-taker, and used two varieties of snuff Kendal brown, and brown rappee. Samples of both were sent to Dr. Campbell Brown, who found lead in the latter. The patient was warned to limit himself to the Kendal brown snuff, and rapidly recovered. Some years later, he was again attacked with severe lead-poisoning. Apparently he had forgotten which was the forbidden snuff, for he had again taken to the brown rappee, in which, as before, lead was largely present. Discontinuance of the snuff was followed again by recovery. The lead was derived from the lead-foil wrapper.—*Brit. Med. Jour.*

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Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

Nitro-Glycerine, Nitrite of Amyl and Nitrite of Sodium in Cardiac and Renal Diseases.—Nitro-glycerine, and nitrite of amyl, have for some time been extolled in the treatment of mitral and aortic diseases, and also in granulated kidney. In a great number of cases these agents act very efficiently, relieving and dispelling some of the most alarming and conspicuous symptoms, such as hæmicrania, the array of phenomena which characterize a paroxysm of angina pectoris, and also many of the phenomena which indicated the presence of uræmic poison. As these affections are manifested by more or less cardiac weakness and high arterial tension, the modus operandi of these medicaments consists in energising the heart's action and lowering the blood-pressure, thiswise relieving anæmia and venous stasis, aiding, thereby, the elimination of effete matter through the renal excretions.

Nitro-glycerine, which may be administered either in solution, one per cent, or in pill form, has the great disadvantage of being uncertain in its action. Sometimes, one single drop or one pill produces very severe phenomena, referable to the head; others, a dose tenfold larger, receives no response from the system. Nitrite of amyl possesses not the inconveniences of nitro-glycerine; is of easier and readier administration (from 5 to 10 drops by inhalation), but its action is transient and ephemerous. It is adaptable to cases of great emergency, as the advanced guard of other potent agents, which require longer time to provoke their physiological action.

Nitrite of sodium is calculated to supersede the other medicaments. It is odorless and without taste, freely soluble in water, and in the dose of one grain, three times a day, is an efficient medicament, in the same pathologic conditions wherein nitro-glycerine and nitrite of amyl find indications. Cerebral phenomena and others referable to the nervous system, when induced by this agent, are of a mild and transitory character, and the benefits derived from it are lasting and manifested a few hours after the initial dose, if it meets with a favorable response from the organism.

On the Formation of Tails in Human Beings.—Prof. Virchow delivered an address at a recent meeting of the Berlin Medical Society, on the formation of tails in human beings, an account of which appeared in the *Berliner Klinische Wochenschrift.* He maintained that, in treating this question, we have to deal with three different things; first, complete tails, of which nothing of importance has been said in recent times; secondly, the usual form of soft imperfect or incomplete tails; and,

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finally, the simple skin-appendages resembling tails, which, properly speaking, have no connection whatever with tails. Prof. Virchow said that, some time ago, he was fortunate enough to obtain a specimen which was of no small interest in discussing the question of the appearance of tails in human beings. It was a specimen that had long been in the University Museum, but had been hidden behind other things, so that nobody knew of its existence. When all the pathological specimens were being moved into the Pathological Institute, this was found.

This question, which has attracted much attention in recent times, is of special interest, not only from a pathological point of view, but also as connected with the general theory of Darwinism. For, when one sees a human being with a tail, the thought revives that this is a return to animal shapes, and it appears a new reason for accepting Darwin's laws of development. The old view, already expressed by Johann Friedreich Meckel, has been everywhere confirmed by recent investigations; namely, that the human embryo does indeed originally possess a projecting end of the spinal cord resembling a tail, so that there is in reality a certain similarity to animals in the early stage of embryonic life.

The other question, whether, under similar circumstances as with animals, tails exist in the thoroughly developed human being, is just as certainly proved. Bartels has given a whole series of such cases, and has shown with no small amount of probability that there are certain nations amongst whom these cases occur very frequently. This idea had previously occurred to a German, Dr. Ornstein, when Surgeon-General of the Greek army. He noticed certain peculiarities of very common occurrence amongst the army recruits, which led him to suppose that the peculiarities ascribed to satyrs and other wood-divinities by ancient sculptors were no invention, but based on a real, though perhaps somewhat exaggerated, phenomenon amongst the Greek nation. The peculiarities that struck him were, thick patches of hair, real protuberances, and finally, even apparent prolongations of the spinal cord and the lower extremity of the back.

Without dealing with the question in detail, Prof. Virchow pointed out the difficulties connected with its explanation; for example, when one sees that, between the formation of hair on the region of the rump and the caudal protuberances of this region, a tertium quid, something between the two, occurs, namely, hairy tails, it is very easy to infer, as Ornstein says, that the whole is a connected system, and that the formations of hair are to be looked upon as a relic of an original caudal formation.

The question would be much clearer, if it could be shown with anything like certainty that, in one or the other kind of these formations, the

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vertebral column, as such, appeared as an element, as a real supporter of the whole formation. The data on this point cannot be relied upon, hence the difficulty. But there are cases of men in whom the tail appears as a real prolongation of the axis, and therefore as proceeding from the vertebral column; but the majority of these prolongations are "soft tails," containing neither bone nor cartilage, resembling a cauda suilla, as older writers called them, and we may class them as "imperfect tails;" for though they are not real tails, they represent the equivalent of a tail. There is also this difficulty, that skin-appendages, resembling tails, are found on all parts of the bodies of monstrosities, for example, in the case mentioned by Elsholz of Colln-on-the-Spree (the old name for Berlin) in 1669. It was the case of a girl with such an appendage on the upper part of the thigh, and with one at the regular place of a tail. It could be said that the appendage on the thigh is in the form of a tail, but is not one; therefore, the other appendage is also no tail. But, said Dr. Virchow, in the specimen before us to-day (a case of a man), one appendage is between the shoulders, the other where a tail naturally occurs. The upper appendage is clearly only a skin-appendage, having nothing whatever to do with the vertebra; whereas the lower one proceeds directly from the coccyx, and is in immediate connection with it. Prof. Virchow said he would not explain how it was that these two, a real and a false tail, occurred together; but from his experience of fœtal misformations he concluded that these skin-protuberances are, as a rule, due to adhesive processes formed in the early stage of embryonic life, and that in the case mentioned, the upper appendage is one of these. He then drew attention to a case previously published by him in the *Zeitschrift für Ethnolgie*, 1875, (vol. vii., page 280), concerning the formations in the region of the rump surrounded by hair, mentioned by Ornstein. Cases of this kind, Prof. Virchow added, were seldom described in Germany, and such pronounced formations of tails as those mentioned are rarely to be seen in collections.—*British Med. Jour.*

Rupture of the Stomach Through Distension by Gas. — The *Revue Medicale de la Suisse Romande* of January, 1885, reports the following remarkable case of Prof. Revilliod (de Geneve):

A young lady, 28 years of age, habitually healthy excepting for paroxysms of gastralgia more or less severe, walks out of the house immediately after dinner, under the influence of a strong vexation, and, in returning, is seized by one of her paroxysms, unusually grave, which is soon followed by acute abdominal pains, rapidly diffused tympanites, culminating by emphysema of the trunk and face, and a fatal issue the morning after.

The autopsy reveals several interesting lesions regarding the stomach: 1. A laceration of the peritoneal coat, seven centimetres long, (2¾ inches)

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on the anterior paries, displaying the muscular coat intact. 2. Many other superficial lacerations on the posterial paries. 3. A total rupture admitting the entrance of four fingers, on the lesser curvature. The rest of the organ contained neither ulceration, cicatrix, pseudo-membranes, adhesions or inspissation, indicating an inflammatory process in the vicinity of the lacerations. It is a rupture through exaggerated distension. The lesions occupying the external coat alone, could not be attributed to an ulcerative process.

As regards the modus medendi of this distension sufficiently strong to provoke a rupture of the stomach, Prof. Revilliod explains it by the rapid generation of a large quantity of gas, due to a meal bolted down in haste, and digestion encroached upon by a fatiguing walk, when the mind was under the influence of an exciting cause.

Under similar circumstances, identical cases, though rare in number, are found in the records of medical literature.

Laryngology.

Edited by GEO. F. HAWLEY, M.D., 125 State St.

Report of a Case of Naso-Pharyngeal Catarrh.—Mrs. C——, age 45, presented herself at my office, for treatment for catarrh of naso-pharynx. On examination of anterior nares, the walls of nasal cavities were found almost entirely covered with incrusted secretion. Posterior rhinal examination revealed the same condition, differing in the latter, only the incrustations were thicker and more extensive, from the fact that a more capacious chamber existed for their formation; the incrustations were not observed to extend below the superior margin of vellum; it is needless to state, in this case, the odor was stifling and sufficient to impregnate the air of the room in a very short time. Having removed the incrustations, I found the mucous membrane of the naso-pharynx a deep red or rather a livid hue, with several points of abrasion in the mucous membrane; the tissues, both soft and hard, were atrophied to a great degree; the nasal cavities were increased to three or four times the size of normal lumen; the cavity of the vault of pharynx was immensely enlarged; her health, of course, was much reduced from this exhaustive inflammation, which had continued to a greater or less extent, for twenty-five years. She complained of cephalagia, neuralgia, rheumatism, indigestion, constipation, palpitation, and a number of other minor symptoms or sequences of catarrh. With the existence of these unfavorable conditions, she began treatment.

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Thorough cleansing of the diseased mucous membrane was instituted;—this cleansing was performed in the mildest manner possible, compatible with entire success in the removal of all secretion. The detergent used was sodium chloride, water and listerine, sprayed by the use of compressed air, rather forcibly, until the crusts were loosened or removed; then mildly until the surface was entirely free of all secretion. In case the tenacious purulent matter cannot be removed by the spray, a bit of absorbent cotton on a probe, gently applied, will accomplish the desired result.

After thorough cleansing, the diseased membrane was covered with a coating of vaseline in which was intimately mixed a little oil eucalyptus and resorcin. This treatment was applied daily for three weeks, then every other day for two weeks, then twice a week for a while, then once a week for some time; during the interval between visits to my office she was instructed to use as a home treatment, daily, the detergent solution given above and fluid cosmoline. The constitutional treatment consisted of tonics and aperients, with corrections in dietetic errors. Under this treatment the patient rapidly improved, and at present writing, which is eighteen months after treatment began, her breath is inoffensive, hard crusts have ceased to form, and the mucous membrane has become notably thicker; though not perfectly well, the case has been improved, her general health greatly restored, and she is able to take her place in society from which she was ostracised. In conclusion, we wish to state that the above is one of those cases which are generally regarded as incurable, and doubtless an absolute cure is impossible, but the degree of palliation and improvement is so great that it is well worth the treatment. —*N. R. Gordon, M.D., Springfield, Ills.*

Adenoid Vegetations.—An interesting article, by Beverley Robinson, upon adenoid vegetations at the vault of the pharynx, appeared in the *Med. Record* of last month. In this paper he states that he has not met with these growths as frequently as some appear to have done. He does not, however, classify as such a simple development of tissue which is similar in appearance and not very unlike in structure to the follicles one sees in chronic pharyngitis. What he calls adenomata or adenoid vegetations are larger and more closely juxtaposed. Only a few of the large variety with smooth surfaces and pink color have been observed by him. The following is a short history of a case, which, according to his experience, represents a type rarely met with, at least in New York city.

E. P., 24 years old, single, saleswoman, born in the United States, entered St. Luke's Hospital, March 8, 1882. One year before entering the hospital she contracted naso-pharyngeal catarrh, which had never left her. Physical examination showed catarrhal discharge from

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pharynx, nasal polypus in right nasal fossa posteriorly, discharge from ears (due to eczema), and excoriation of parts about external meatus.

April 3d.— Examination of larynx showed some inflammation and clubbing of left atenoid cartilage.

13th.—Patient has considerable pain in throat and some huskiness of voice. Posterior rhinoscopic examination shows ulceration of mucous membrane covering inferior turbinated bone on left side. Adenoid growth just behind upper portion of septum and apparently adherent; both Eustachian tubes open and full of mucus.

26th.—Raised a little blood this morning.

30th.—Adenoid tumor above described removed by aid of snare écraseur (Bosworth's modification of Jarvis's), the loop being introduced through the naso-pharyngeal space. The tumor was easily engaged in the loop, and came away with slight hemorrhage. The growth as removed was about the size and shape of a chestnut, and had apparently a distinct pedicle.

May 12th.—No vestige of the tumor made out. A few adenoid growths were seen on the posterior portion of the septum. Dr. Robinson operating rubbers were passed through the nose and drawn through the mouth and fastened behind the head. In this manner the soft palate was drawn forward and upward out of the way. A small, blunt uterine curette, bent to the proper angle, was passed backward and upward through the fauces and into the posterior nares until the growth was reached. It was then a very simple operation to scrape it off. Little or no hemorrhage resulted, and the patient suffered only slight pain.

20th.—No sign of return of the tumor. Cough has disappeared. No discharge from the ears; still slight clubbing of left cartilage of Wrisberg, with considerable redness. *Discharged improved.*

Contrary to the experience of Meyer and others he has never met with a single instance in which deafness was caused by these growths compressing the Eustachian orifices. Deafness is due rather to the accompanying catarrh extending into the Eustachian tube or middle ear. The adenoid hypertrophies have usually been moderately soft to the touch, bleed but little if examined by the finger with a proper degree of gentleness. His further description agrees in the main with those generally given; the growths are usually covered with a grayish viscid mucus which is difficult to expectorate, and causes a sense of uneasiness to the patient. Though there is often a muffled and defective speech he has never observed, to any marked degree, the loss of power to pronounce certain consonants in an intelligible manner. Meyer lays great stress upon this point and of a peculiar dead character of voice, differing from the dull and thick speech of enlarged tonsils.

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However, a peculiar stuffy pronunciation, particularly in pronouncing the nasal consonants, is frequently present. This is due to the fact that the nasal passages have lost their normal resonance.

He says: "Whenever I have remarked any very great amount of thick grayish or greenish mucus in this region I have always found on further examination a considerable degree of hypertrophic nasal catarrh." Our experience has led us to look for hypertrophic nasal catarrh in all cases where the adenoid vegetations are sufficient in number or size to cause impairment of speech or nasal respiration. We agree with the author in not considering the pinched, contracted appearance of the nose, or the broad configuration at its base as pathognomonic of this disease. "The retracted lips, open mouth, receding gums, protruding teeth, especially the upper, shrunken alai, diminished size of the orifices of the nostrils, the wrinkles at the outer angles of the eyes; and the lines extending from the alai of the nose to the angles of the mouth," which Wagner gives in his work on Habitual Mouth Breathing, as an indication of adenoid growths, are more apt to be caused by a long existing obstruction to the passage of air within the nasal passages, rather than to any hyperplasia of adenoid tissue in the post-nasal space. Regarding the number of cases complicated with ear disease, the author again differs with Meyer who affirms that the best place to observe adenoid vegetations is among ear cases. Dr. Swinburne reports out of 42 cases seen by him, 27 were found with ear trouble, and of 102 reported by Meyer, 72 suffered from ear complications. The difference in their reports and the author's experience, he reconciles by assuming that they do not absolutely agree upon what is an abnormal growth of adenoid tissue. What he might consider as consistent with a healthy or normal aspect, they might class under the head of adenomata. Some are apt to pronounce any marked deviation of tissue in the vault of the pharynx as abnormal, forgetting that there are individual idiosyncracies here as elsewhere. Woaks, in a paper read before the Medical Congress of 1881, stated that when vegetations are seated at the vault, the aural complication is more likely to be suppurative otitis, while if on the posterior wall a complete mechanical occlusion of the Eustachian tubes may follow, due to the great thickening of the adjacent mucous membranes. This produces chronic non-suppurative inflammation of the middle ear. He also discards the name of adenoid vegetations, considering it a misnomer, and gives quite an exhaustive argument to prove that it is a papelomatous or warty growth, and not a hypertrophied glandular tissue. Marked follicular pharyngitis seldom occurs without a coexisting hypertrophy of Luschka tonsil. So it is worth the while whenever this disease is present, to make a careful examination of the retro-nasal space, even if the symptoms are not sufficient to direct your attention to it. The

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hereditary tendency to transmit this disease shows itself in several instances which have been reported. Regarding treatment, the author had nothing new to suggest. He preferred Meyer's to all other cutting operations recommended by the various writers on this subject.

It is particularly advised in the removal of flat sessile growths of small size. By means of tolerably thorough scraping he says "I have unquestionably benefited those patients, though never effected an absolute cure." So many cases present themselves in which, due to deflected septum or bony growths, Meyer's ring knife cannot be used. Here it is necessary to employ an instrument so made as to pass back of the palate to the vault. Thomas' blunt wire uterine curette, bent so as to adapt itself to the parts, will be found of great service. Not having a cutting edge, it can be used without fear, until you are satisfied the growths have been removed. Within a few days after the operation, apply fused nitrate of silver or the galvano cautery to what remains. He favors strongly the operation by the galvano-cautery, particularly where the curette cannot be used or where the growths are in adult patients with tolerant throat and capacious naso-pharynx. Jarvis' écraseur, however, is better suited to operations upon pedunculated growths. The soft palate must be drawn forward and Wales' method is probably as satisfactory as any. The best electrode is an instrument composed of two copper wire conductors, separated from each other by some insulating material, bent at nearly a right angle toward its distal extremity, terminating in a small spiral of platinum about two or three lines in breadth, and wrapped in ordinary white cotton thread or a thin layer of absorbent cotton and cotton thread. The platinum spiral is protected by a shield made from the outer layer of asbestos. It is less bulky and does not chip like that of Lincoln's. The electrode is introduced cold, aided only by the rhinoscopic mirror. When fully located the current is then passed; only a red heat must be given to the platinum, the force necessary first being ascertained by a previous trial with the battery. Not too much burning should be done at an operation, but repeated sittings be given at intervals of a week or more. As a rule this operation with the galvano-cautery for the destruction of adenoid vegetations has not been received by marked favor by the specialist. The inflammation excited and the difficulty of so managing the electrode as not to injure adjacent parts have forced it out of general use. Either the cutting forceps of Woaks, modified by Semon, or the wire loop, as employed by Jarvis, Bosworth, Hartmann and others, is generally preferred. The wire écraseur of Hartmann differs from the others by having the wire loop enclosed within a ring attached to the instrument. By this means, the growths being crowded within the ring, are more thoroughly crushed. At the Throat and Chest Hospital at London, Woaks' forceps only are

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used, and in case of children, always under an anesthetic; a complete removal is attempted at one operation. Meyer's instrument consists of a little ring, oval transversely, one edge sharp, and attached to a flexible stem which is inserted into a roughened handle. This instrument is to be introduced through the nasal passages, the growths scraped or cut off by the ring.

Dermatology.

Edited by HENRY J. REYNOLDS, M.D., 2200 Michigan Ave.

Treatment of Eczema.—Allow me, Mr. Editor, to present to your numerous readers a brief report of a case of eczema that recently came under my observation and treatment. I wish to say en passant that my object in publishing this article is not so much to bring the treatment (for in this I have introduced nothing new) before the notice of the profession, as some of the difficulties that beset the general practitioner in the management of such stubborn and easily relapsing cases.

A— C—, aged 2 years and 8 months, of German parentage, came under my care Nov. 1st, 1884, suffering from a chronic form of eczema impetiginosum which she had contracted when only six months old. Her face was almost completely covered with scabs, except where these had been removed by scratching, and from this cause her face presented a ghastly sight, from the lacerated appearance of the cuticle and the blood streaming from the face. I at once proceeded to get as faithful a history of the case as was possible under the circumstances. I could not trace it to a specific origin, but the parents told me they were sure it had contracted the disease by being placed in a crib with another child suffering in a similar manner, and which afterward died of the disease. To all appearances the parents were in perfect health nor had either of them ever suffered from an eruption of any kind, nor were they aware that any of their ancestors had ever suffered in a like mander. Suspecting, however, a syphilitic origin, I placed my patient under the iodide of potassium treatment, combining this with ext. sarsæ fl. and liq. arsenicalis, while locally I applied ung. hydrarg. ammon. to scalp (after having first clipped off the hair) and face, while to the extremities I applied ordinary pine tar. Under this treatment she rapidly improved until in three or four weeks there was scarcely a trace of the disease. I then ceased my visits after first enjoining upon them to show her to me at my office, especially if any disposition to a relapse manifested itself. This they neglected to do until the disease had become pretty nearly as bad as I found it in the first place. Since then I have not seen my patient, the parents, no doubt, having de-

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termined to let some other medico try his skill for a week or two, when, getting tired of this one they will try some other, and so on ad infinitum. I might also add *in re* the treatment, that my patient rapidly regained her strength under the administration of emulsion of cod-liver oil. The majority of failures with which medical men meet in the treatment of cutaneous diseases is no doubt due to this propensity on the part of their patrons to become discouraged when they find out that they are not invested with the power of working miracles, and in order to discharge our whole duty not only toward our patients but also toward ourselves we ought particularly to warn the patient and friends to the great susceptibility this disease has to relapse, and also its chronic character. Almost any mild case may be cured in a short time with the ammoniated mercury ointment, as many general practitioners as well as specialists can testify, and, without constitutional remedies. However, it is better when a syphilitic origin is suspected to place the patient under specific treatment as well. Would further add that on the return of the patient after relapse, the chrysarobin treatment internally, so highly recommended by Stocquart (*Annales de Derm. et de Syph.*) and recently abstracted in your journal, was thoroughly tried without any benefit whatever.—*Wm. Minaker, M.D., 348 26th St., Chicago.*

Favus in an Infant.—Dr. Kate Parker, Resident Physician, New York Infant Asylum, reports a case (*Jour. Cutan. and Vener. Diseases*), as follows: Robert Berry, healthy, well-developed infant, born March 19, 1883; weight at birth, six pounds two and one-half ounces, mother primipara, 23 years of age, always healthy. No family history of skin disease. A few days after birth a red spot was noticed on right side of infant's head, circular in form, about five lines in diameter. Did not increase in size or present any characteristic appearance for the first four weeks after birth, when a small yellow cuplike disc, having well defined border, appeared in centre. This gradually increased in size, and was followed by others. No treatment was given until infant was 7 months old. At this time the original spot had increased somewhat in size, and in addition had sent out a spur-like prolongation posteriorly, eight lines in length by two in width. This, as well as the circular spot, was covered with favi of varying size, numbering in the aggregate fifteen.

At this time the patient was first seen by Dr. Piffard, who pronounced it a case of favus, and confirmed the diagnosis by making a microscopical examination of one of the cups, finding the achorion schoenleinii in abundance. Treatment—Removal of crusts; painting surface with tinct. iodine. This was continued at intervals of from two to three weeks, according to appearance of favus cups; the surface affected gradually becoming smaller and intervals longer before the appearance of the favi.

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Seven paintings in all were resorted to, when the cups entirely disappeared, leaving a slightly reddened surface. At this time the little patient left the asylum and passed from observation.

Adherent Ulcers.—James Hardie, M.D., Edinburgh, in speaking of the condition usually described as "indolent ulcer," intimates that the exact pathological condition is much better implied, and hence the correct treatment better suggested by the term adherent ulcer. In all such ulcers there had previously been an inflammatory process; as a result the loose cellular tissue on which the wound was situated became infiltrated with plastic lymph, extending to a greater or less depth; even in some cases down to the superficial fascia, or in case of destruction of the latter, the parts may become infiltrated as deep as the muscular aponeurosis. In process of time this plastic material undergoes the changes usually incidental to it; it becomes less soft, more organized, dries up, and, in short, is converted into dense cicatricial tissue, almost as dense as cartilage and almost as destitute of vessels. Thus the ulcer becomes incorporated with and adherent to the subjacent fascia, and thus its base becomes converted into a tissue, with no adaptability for carrying on the processes essential to healing. All such ulcers have a strong tendency to present, in process of time, the characters of "indolence," more especially as regards the appearance of their surface. These ulcers may vary in external appearance owing to their location, but in all, the underlying condition is the same; there is hard, dense, unyielding, poorly nourished tissue, which has become, through organization of the exuded plastic material, adherent to the deeper parts. Such ulcers, of course, have no spontaneous tendency to heal; a condition of affairs which is more especially maintained by the adhesion to deeper parts.

He says of the treatment: Having regard to the fact that the ulcer is intimately attached to an unyielding fibrous structure, which is itself also infiltrated with inflammatory deposit, and bearing in mind also that there is a sense of resilience in this structure when it is firmly pressed, I infer that beneath this indurated base the tissues are not thus infiltrated, but are probably in their normal condition. If, then, I expose this normal tissue, I may reasonably expect that it will follow the course which an open wound in normal tissue generally follows—that is, it will produce granulation, which is the condition we are so desirous of seeing take place in the ulcer. It is very easy to accomplish this. No serious operation is required, such as excising the whole ulcer, or even its edges. All that I am going to do is to make a crucial incision right across the ulcer, from soft skin on one side to soft skin on the other. I must take care to go deep enough—deep enough, that is, to divide completely the infiltrated tissue, and expose the normal tissue beneath. The immediate effect of

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this will be that the elasticity of the cicatricial tissue will cause the edges of the incision to spring apart, leaving four gaping wounds in the base of the ulcer, with four gristly tongue-like processes projecting from its sides. A few days after an operation such as this I confess that a somewhat alarming appearance generally presents itself to view; and I have known house surgeons, who have seen it done for the first time, quietly have their own thoughts about the affair. But the more alarming it looks, the better. What happens is this. The soft tissue at the bottom incisions pushes up its granulations. The old cicatricial processes retract more and more. The edges of the ulcer retreat. Bright, vigorous, granulations fill up the gap, and at the end of a week the ulcer is twice the size it originally was. Then the alarming period comes to an end. Soon you find a healthy sore established and healing goes on apace. Nothing can be more satisfactory than the extraordinary rapidity with which healing is accomplished under these circumstances. I suppose that the healthy granulations, pressing on the old cicatricial tissue, insinuate themselves into it, and cause it to become absorbed, for in a short time it is indistinguishable. You thus establish a healing sore in place of an indolent ulcer. I need not say that healing sores do not always go on to heal uninterruptedly. If they are large they probably will not. But do not forget how much you can do by the process of skin-grafting. It would be perfectly futile to attempt to graft this ulcer in its present condition. To succeed in that operation you must have a healthy bed for your grafts. Do not waste your time nor annoy your patient by attempting it on an ulcer which is indolent, or callous, or weak, or inflamed; but get it somehow into a healthy condition, and then seize your opportunity. In this manner many an ulcer which had been for years a trouble to its possessor may be expeditiously and soundly healed.

A word as to the method of operating. You must make as many incisions as are necessary to liberate the parts perfectly, and you should place them where the ulcer seems to be hardest or most adherent. Above all, you must carry the knife completely through the hardened tissue. This cuts like a raw potato, and when you have first of all made a clean deep cut, it is well then to continue scratching the bottom of the latter with the point of your scalpel. You will know the first time you do it, from the abrupt cessation of the peculiar harsh sensation, when you have reached the soft tissue underneath. Occasionally you will have to go pretty deep—say three-quarters of an inch—more frequently less than this. Occasionally also you will cut a large vein. That you had better tie for its mouth remains widely open.

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Surgery.

Edited by G. FRANK LYDSTON, M.D., 125 State St.

The Relations of Myxœdema and Cretinism to Each Other, and to Excision of the Thyroid Body.—In a recent letter to the *Medical Record* a correspondent relates a case of myxœdema which was presented to the Medical Society of London, and which excited considerable interest. The case had begun with a severe hemorrhage, and a tendency to hemorrhages had subsequently persisted. Attacks of nervous restlessness were also complained of. It was noticeable that marked improvement occurred under half-drachm doses of the fl. ext. jaborandi. Apropos of the subject of myxœdema, attention was called to the statement of Kocher to the effect that he had noticed a condition of cachexia closely resembling myxœdema, following excision of the thyroid body. Kocher suggested the theory that myxœdema in the adult might be the analogue of cretinism in childhood. Bruns reports a case of myxœdema following excision of the thyroid, which condition is so closely associated with cretinism as to suggest a blending of the two affections. There are some strongly suggestive clinical facts in these cases, which are well worthy of careful study. It would seem probable that there is some undefined physio-pathological relation existing between a number of diseases in which the thyroid is more or less implicated, but we believe that it will not be satisfactorily explained until we know more of the anatomy and physiology of the trophic nervous system. That there is such a special system is denied by very able authorities, Flint, in particular, discrediting it; but there are many facts, both anatomical and physiological, which seem to be evidence in favor of its existence. Whether it be merely a part of the general ganglionic system or not, is not of great practical importance. If it existed merely in the fact that the general sympathetic system is endowed with a special, or trophic function, it would not affect the practical bearing of tropho-neuroses upon certain nutritive disturbances. Functionally, at least, the trophic nerves are an entity. We have, in exophthalmic goitre, or Grave's disease, a condition which is quite constantly associated with disease of the cervical sympathetic and its ganglia—and we believe of the general sympathetic system as well. The thyroid gland is not alone in its pathological disturbances in this disease, for the true glandular system may be involved. We have at present a case under observation in which the liver is enormously enlarged. The spleen is also of considerable size. The thyroid, however, is usually the structure most markedly involved, and is often the seat of the only perceptible change aside from the exophthalmos, and certain cardiac disturbances. Such cases illustrate the important nervous relation of the

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thyroid body to the central sympathetic. Recognizing this important relation, it is easy to conceive that surgical interference with the thyroid might produce serious disturbance of the central sympathetic system, and in view of the trophic functions of the latter, such a nutritive disturbance as occurs in myxœdema would not be a surprising result. We know that peripheral lesions of the sensory and motor nerves often lead to serious disease of the cerebro-spinal centers by ascending degeneration, and such an occurrence is surely not much more reasonable than the supposition that peripheral lesions of the sympathetic nerves may produce central sympathetic disturbance.

The result of surgical interference with the thyroid, or of disease of that body, might be either cretinism or myxœdema, or a combination of the two, according to the age of the subject. The cases of cretinism occurring in young subjects may be assumed to be general disease, with profound disturbance of nutrition due to primarily-central trophic disturbance. In these cases the circumstances of age, environment, heredity and hygienic errors, are sufficient to account for the distinctly pronounced type of disease. In the case of myxœdema reported to the London Society, the occurrence of hemorrhages and the beneficial effect of jaborandi, are both strongly suggestive of the important bearing of vaso-motor changes upon such cases.

A Case of Radical Cure of Inguinal Hernia.—Modifications of the old operation for the cure of hernia, by the excision of the sac, have been rapidly assuming a prominent position as recognized surgical procedures of recent years, the revival of the method being due solely to the indefatigable efforts of Sir Joseph Lister, to bring his antiseptic method into prominence, and to demonstrate the safety of operations involving the peritoneum, when performed under antiseptic precautions. He was therefore an early pioneer in the field, and is among those who have succeeded in showing that even in the operation for strangulated hernia, it is not very frequently that peritonitis is the cause of failure and a fatal result. It has been shown, as we now are well aware, that the peritoneum may be handled with impunity as long as it is not septicised by careless and unclean manipulations. Annandale, Banks, Spanton and Whitson are among those who followed in the footsteps of Lister, and who have given their results to the profession. Banks has published a record of thirty cases,* the results of which were in the main excellent, and which have led him to the following conclusions:

"1. The sac operation, i.e., excision, is applicable to herniæ of all conditions, and especially to those in which there is adherent omentum in the sac.

*Brit. Med. Jour., Nov. 18, 1882.

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"2. As far as my thirty cases go, it is shown not to be a dangerous operation, while its results, from a curative or remedial point of view, are most satisfactory.

"3. Radical cure should form a necessary part of all operations for strangulated hernia."

Annandale has contributed an excellent essay on the radical cure of rupture,* and has enumerated four principal methods of operation, viz., 1, ligature of the neck of the sac; 2, ligature of the neck of the sac, with invagination of the sac into the abdominal opening; 3, ligature of the neck of the sac, and excision of the sac below the ligature; 4, ligature of the neck of the sac, with excision of the sac and stitching together of the margins of the abdominal openings. Of these operations he prefers and endorses, unqualifiedly, the fourth method. There is one conclusion reached by Mitchell Banks, that deserves serious consideration and universal acceptance, and that is the application of the fourth method mentioned by Annandale, to all herniæ requiring herniotomy for strangulation. It would appear that in the light of recent researches as to the cause of death following herniotomy, that the proper procedure would naturally be the radical operation as supplementary to the liberation of the strangulated gut. By this method, the peritoneal cavity is at once effectually closed, and a clean wound may be left, which is not so true of the ordinary operation. The extensive surface of peritoneum involved in the sac, cannot do otherwise than enhance the danger of sepsis and inflammation of that membrane, during the process of healing. By cutting it away, we remove that tissue from which the greatest danger is to be feared, through which it has had such abundant opportunities to become infected during the operation.

Herniotomy, under proper precautions, may be made a pretty successful operation, as is illustrated by a series of seven successful cases reported by Shrady,† and it is probable that the popular application of the radical operation will render it universally of favorable prognosis. There is one thing that is positive, viz., that this method of operating for strangulated hernia will necessitate a freeing of the sac, prior to its being opened, that will prevent the destruction of the patient by a deliberate reduction *en masse*, and an opening of the sac that will free the operation of the danger of reduction of the gut with a strangulation by adhesive bands, unrelieved.

It would seem hardly necessary at the present day to warn surgeons against reduction *en masse*, but a case recently reported‡ illustrates its

*Edinburgh Med. Jour., Dec., 1880.
†N. Y. Med. Rec.
‡Northwestern Lancet, Nov. 1884.

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necessity. In this case the hernia was exposed and deliberately reduced *en masse*, without opening the sac. The strangulation being unrelieved, twenty-four hours were allowed to elapse before laparotomy was performed. A fatal result was the natural consequence. A supplementary removal of the sac, after liberation of the strangulated gut, would in all probability have saved this patient, for he was an exceptionally favorable case for operation.

The details of Banks' operation are well worthy of attention, and I therefore liberally quote his remarks upon the subject, verbatim: "I use thorough antiseptic treatment, and make a point of having the pubes and parts around the anus most carefully shaved. In an inguinal hernia the incision should commence at least an inch above the upper margin of the external ring, so that plenty of room may be given thoroughly to clear the pillars for the stitching. The sac is next freed from the surrounding tissue, and this is often much more troublesome than might be imagined. One is almost always tempted to think that it has been reached long before it really has; so that frequently, after a considerable amount of stripping has been done, it is found that it is not the sac at all that is being cleared, and the process has to be done over again. It is this mauling of the loose cellular tissue of the scrotum that gives rise to nearly all the trouble that occurs in the way of suppuration. The sac ought to be fairly reached before any stripping is done. Another point is, that in the case of an old sac, the lowest point is intimately adherent to the tunica vaginalis; and, if it be roughly pulled upon, the testicle enclosed in the tunica comes bodily out of the scrotum—not a very serious matter it is true, but unpleasant to look at. The sac having been cleared, its contents are pressed up into the abdomen. When it is thin there is no difficulty in making sure that it has been completely emptied; but if there be the slightest doubt, it should be slit up and its interior examined. Adherent omentum, if in small quantity, I separate carefully, tie with catgut in one piece, and cut off; if in large mass I split it up into two or three portions, and ligature with carbolized silk to ensure a good knot that will not slip. One cannot be too careful about the securing of the omental stump before it is finally pushed into the abdomen, and every drop of bleeding should have ceased, both from the omentum and from the neck of the sac before the next proceeding. This consists in pulling the sac well down, and tying it as high up as possible. I use two ligatures of strong catgut, as that material is apt to be treacherous. In case anything should happen to one the other is there. With a curved needle, armed with strong silver wire, I next pull together the pillars of the external ring, leaving only room for the spermatic cord at its lowest part; two or three stitches suffice. These are cut short off and left in situ.

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A clean carbolized sponge put beneath antiseptic gauze for the first twenty-four hours makes the best dressing."

Whitson advocates essentially the same operation, but uses chromicised catgut instead of silverwire.* In the case which I shall relate, considerable modification of the operation was necessary, on account of certain peculiar features of the case itself.

F. M., age 22, occupation, farmer; presented himself to me in March, 1885, to have a truss applied to an inguinal hernia. He was a robust, athletic young man, but of a marked nervous temperament. Had always been very healthy, never having had any disease with the exception of cystitis (?) which his surgeon said was due to the pressure of a truss which he was wearing. About the same time he was affected with what was termed "an attack of gravel." He could not remember having had any abnormality of the testicle, although not positive in regard to the matter, but he never had anything of the nature of hernia until two years before visiting me. At that time he was trampled upon by a horse, the hoof striking him in the groin, and injuring him severely. Pain in the groin, nausea and vomiting immediately set in and lasted for some hours. On attempting to get up, after these symptoms had subsided, he noticed a swelling in the left groin. This persisted subsequently, appearing in the daytime when upon his feet, but subsiding at night. Some ten months prior to my examination, the hernia began to trouble him greatly, being increased in size, painful, and constantly protruding. He therefore consulted a surgeon who applied a truss, which, however, failed to retain the rupture. Since that time he had tried a dozen surgeons, and a "wagon load of trusses," but without success, the annoyance being merely aggravated. On several occasions the hernia became strangulated and inflamed, necessitating taxis for its relief. He finally concluded to come to Chicago for further advice. I found upon examination a direct complete hernia in the left groin, which was easily reducible, but very sensitive to pressure, the neck of the sac being apparently thickened and inflamed from manipulation and ill-fitting trusses. The abdominal opening was quite large and the canal quite short. Altogether there was little to hope for from trusses, although I desired to make the attempt to secure one which would retain the hernia before deciding to operate. The left testicle was greatly atrophied and the cord nodular to the feel. After fruitless attemps to attain the desired object with various forms of trusses, the young man decided to have an operation with the comforting assurances of his surgeons at home, that I "would surely kill him," the radical operation being evidently unpopular in that neighborhood. The case was evidently not suitable for a trial of the Heatonian operation, and con-

*Braithwaite, July, 1883.

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sequently the excision of the sac, with a possible removal of the probably useless testicle was the only feasible operation. I therefore operated on March 19, '84. I found on exposing the sac, that its neck was greatly thickened from inflammation, the spermatic cord and upper part of the sac being matted together, so as to make them separable only with some difficulty. The testicle was apparently rudimentary, the cord, however, being thickened and nodular. As the prospects of its ever being functionally useful were very poor, and the benefit to be derived from its removal great, I decided to remove the organ. The sac being thoroughly freed, was drawn down, ligated, and cut off close to the ligature. The stump of the cord and the neck of the sac were then stitched to the upper angle of the external ring, with strong silver wire, and the entire opening was then closed by stitching the pillars of the ring together. Three sutures of silver wire were used, and as an additional precaution, three of chromicised catgut were inserted. The wound was irrigated with bichloride solution, a drainage tube inserted, and after closure,. iodoform and gauze dressing applied. Union of the external wound by first intention occurred, but the deeper parts suppurated, and delay in healing was caused by the occurrence of cellulitis of the pelvic sub-peritoneal aerolar tissue, which resulted from the entrance of the antiseptic irrigating fluid entering the pelvis through the inguinal canal while a careless nurse was dressing the wound. At the end of about six weeks, however, recovery was perfect. At the present writing the patient is perfectly well, there having been no recurrence of the hernia, although he has been actively engaged in farm labor for the better part of the time. There has been no inconvenience from the silver sutures. That greater reliance can be placed upon the silver than upon catgut is evidenced by the fact that by the end of the second week after the operation, all the chromicised sutures came away in the discharges. I must say, however, that they were still tightly tied, and capable of resisting considerable strain, having evidently cut through the tissues. The suppuration and delay in healing were of course not a desirable feature of the case, but I confess that I believe the good result to be due mainly to the amount of new tissue formed during granulation, and which firmly blocked up the canal. The result was of necessity better than would be expected in a case which did not require removal of the testis.— G. F. L.

Case of Operation for Sacculated Empyema with Associated Pulmonary Abscess.—Mrs. A., aged 50 years, occupation housewife, first came under my observation about one year ago, while suffering from an attack of biliary colic, of a severe character. She gave at that time a history of obscure abdominal trouble dating back to the great fire, at which time she was exposed to cold and damp for some weeks. She had experienced

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since that time, almost constant pain in the abdomen referred to the region of the liver, with periodical paroxysms, which previous attendants all pronounced "attacks of gall stone." Under treatment, she improved and has had but one attack since my attendance upon her. About the 20th of January last she began to have pain in the left side, with difficulty of breathing, and Jan. 27 I was called to see her. I found a well marked pleuritis generally diffused over the left side, the friction murmur being well marked. Large doses of morphia were necessary to allay the pain. There was an area of dullness and bronchial breathing posteriorly, indicating a probable implication of the lung tissue proper, thus constituting a pleuro-pneumonia. In a few days, there was considerable effusion. The temperature and pulse continued high for several weeks, leading me to suspect purulent deposit. I therefore aspirated, but succeeded in removing not more than 5 or 6 oz. of clear fluid. In a few days, the aspiration was repeated, with the same result. The fever lessened somewhat after each operation. The patient's condition remained about the same for four or five weeks, the fever still persisting, and the stomach being utterly intolerant of medication. During this time I repeatedly sought for pus in the implicated area of the chest, which had diminished to a space about the size of the palm, and in which there were most positive signs of fluid, and finally succeeded in withdrawing a small amount of pus, and suggested an operation. As about this time there were evidences of tubercular deposit in the apices of both lungs, which were borne out by cough and expectoration which had now set in, I had no hopes of the final recovery of the patient, but hoped to prolong life and render her more comfortable by the operation.

The operation was performed Mar. 7. I was obliged to operate between the ninth and tenth ribs on a line with the angle of the scapula, and in order to gain free access to the pleural cavity found it necessary to trephine the upper border of the ninth rib. On opening the thorax, a small amount of pus escaped, which had existed in a small sacculation opposite the site of the operation. On passing the finger into the chest, it perforated the inner wall of the sac, which appeared to be a layer of lung tissue and found a cavity the size of a small orange, containing pus and broken-down lung tissue, pieces of which were washed away in irrigating the cavity. There seemed to be several compartments to this cavity, surrounded by lung tissue. Two moderately large perforated drainage tubes were introduced, and the cavity irrigated with iodized water. Antiseptic dressings were then applied. Since the operation, the patient has been pretty comfortable, and the temperature has reduced slightly. On the whole there has not been the benefit from the operation that I expected, but this is probably explained by the presence of tubercular de-

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posit, which serves to maintain elevation of temperature. The cough however, is much improved. It is now two weeks since the operation, and the temperature still remains from 100° to 101° F., although the general aspect of the case is somewhat better. Had it not been for the probably tubercular nature of the case, Estlander's operation would have been the proper procedure, but it would hardly have been judicious to perform an operation of more serious character than the one described, and thus unnecessarily complicate the case. It seems to me that in cases of limited purulent effusion, it is not necessary to make a counter-opening, as by using the double drainage tube, we get a counter current during irrigation, that is amply sufficient to remove the fluid as fast as introduced, thus laving the cavity mos t thoroughly. It has been my experience in such cases, that persistent nausea is strongly indicative of purulent formation in thoracic inflammations.—G. F. L.

Treatment of Parotid Fistula by the Injection of Fat or Oil.—Dr. Molliere, of Lyons, France, has resorted to an ingenious device, employed by experimental physiologists, in order to cure an external fistulous opening, associated with one lobe of the parotid gland. His patient was a girl of sixteen, who had submitted to a plastic operation. Dr. M. first dilated the duct of Steno, and reduced the fistulous discharge as much as possible, and then resorted to the plan employed by Claude Bernard for the arrestation of the pancreatic secretion. For this purpose Claude Bernard, according to the *Revue Medicale*, injected melted tallow or butter into the pancreas by the canal of Wirsung, and, succeeding in this way in destroying the functional activity of the gland, he also demonstrated the possibility of destroying the activity of the parotid gland in a similar way. To utilize this principle, Dr. M. injected carbolized oil into the fistulous tract, and although his first effort was not successful, his second attempt, which was preceded by a dilatation of the fistulous opening, accomplished the desired object, and the wound healed rapidly of itself. —*St. Louis Weekly Medical Review.*

Tetanus Treated by Ether Spray.—Dr. Bouteiller has communicated to the *Progres Medical* a case of traumatic tetanus and another of chorea treated successfully by him, with the application of ether spray on the spinal column. A man whilst driving struck his horse with the end of the reins, and received the *contrecoup* upon the third finger. A small wound, which bled profusely, was the result, and a week afterward cicatrization was complete. However, his business called him out again, and he had to make a long journey when the weather was very cold. On returning he felt great oppression, and two days afterward he could with difficulty open his mouth, and in the night of the same day he was seized with constriction in the chest every five minutes. When Dr. Bouteiller

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arrived, he found the patient motionless in his bed, the jaws tightly shut, and the lateral muscles of the neck contracted, opisthotonos well marked. A purgative was ordered, and pulverizations of ether on the spine every hour or five minutes at a time. The next day the patient was notably better. Calabar bean according to the formula of Watson was also administered. From this time the attacks diminished, and ether spray was kept up every two hours for a few days longer, when the patient was considered entirely convalescent. The second case was no less striking. A boy, aged eleven, was suffering from well-marked chorea, for which he was treated with opium, bromide of potassium, arsenic, and calabar bean, for five weeks without the slightest advantage. It was then that the author thought of the treatment of Lubelski. Ether spray was applied to the spine morning and evening from three to five minutes at a time. The second day the boy was better, and at the end of a fortnight of the treatment all chronic symptoms had ceased and never returned.—*Med. and Surg. Rep.*

Treatment of Buboes by Aspiration.—In a note to the *Indian Med. Gazette* for June, Mr. Weston, of the Meerut Hospital, states that he has seen two cases of bubo successfully treated by the late Surgeon-Major Hogg, by means of the pneumatic aspirator. "The men," he says, "went out of the hospital much sooner than they would have done had the burboes been laid open. In one case the operation had to be repeated once. A pad and bandage were used after the pus had been drawn off. In our military hospitals, where the ordinary plan of laying open the bubo is practiced, one often sees the resulting sore take an unhealthy action, and, as a consequence, the men are kept in hospital for several months. It would be well, therefore, to give the aspiration treatment a thorough trial."–*Br. Pract.* We are of the opinion that this method of treatment would be disastrous in virulent bubo. Chancroidal pus must sooner or later make for itself a free exit, by sloughing of the superlying structures. After aspiration of such an abscess, the chancroidal process would continue, and troublesome burrowing result. A free opening, followed by cauterization and antisepsis, is the proper treatment, and it is just as impossible to treat such a case successfully in any other way, as to prevent a virulent bubo from suppurating.

External Massage in Stricture of the Urethra.—After recalling the difficulties which are encountered in the treatment of stricture where there is much swelling of the parts and thickening of the periurethral tissue, Dr. Géza v. Antal describes some cases which he has treated successfully by rubbing and manipulating the urethra externally.

He recommends this method as specially applicable to chronically inflamed almost impassable strictures in which no instrument will pass,

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and the water only dribbles away by drops. The following example will serve to show how the operation is performed, and in what cases it is applicable. A man, forty-eight years old, applied for relief, as he could only pass his water in drops after much straining.

After being put to bed, and warm baths and poultices had been employed, no abatement of the symptoms had taken place, and there seemed nothing left but urethrotomy. In these circumstances, Dr. G. von Antal gently rubbed and manipulated the outside of the urethra in the perinæum for about ten minutes daily. On the third day the symptoms improved, and a small metal sound passed, and on the removal of this, a small flexible English catheter, and in seven days the stricture was dilated to No. 14 English. The manipulation process was continued each day, as well as the passage of catheters. By the end of the week, the thickening had considerably abated, and the patient was in every way improved. It has of course yet to be determined whether these results are more lasting than those obtained by simple catheterism; but from the rapid absorption of the effusion round the urethra, it seems probable that they may be so.—*Centrabl. für Chirurgie*, p. 369, June, 1884.—*Pract.*

Treatment of a Dermoid Cyst.—Dr. Baker reports the case of a hospital patient who was considered to be suffering from pelvic abscess. The aspirator-needle, carried up behind the uterus, gave a fluid-like pus; a free incision opened the peritoneal cavity, into which the air entered with a good deal of noise. The fluid proved to be not pus, but fat, and upon this circumstance was founded the diagnosis of dermoid cyst. An incision, about an inch long was made into the cyst, and its edges united with those of a corresponding incision in Douglas's pouch. Injections into the cyst were repeatedly made; at one time a mass of hair presented and was removed, and later tissue containing teeth and bone came away. Knowing the difficulty of destroying the interior of these cysts, Dr. Baker passed a Sims' speculum into it, and applied the thermo-cautery to the whole surface. This was done four years ago, and the patient has remained well since, with no appearance of any return of the cyst.—*Boston Med. and Surg. Jour.*, January, 1884.

—One of our friends adds a new disease to the nomenclature, "Broncheatis of the Stomach." It is needless to state that the discoverer was not a Western graduate. Strange to say, gastrotomy was not proposed, and the micrococcus still reposes in his little nidus.

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Obstetrics and Gynecology.

Edited by E. P. MURDOCK, M.D., 130 S. Halsted St.

Observations on the Diagnosis of Tumors of the Ovary.*—Most physicians regard symptoms as manifestations of disease, or rather phenomena by which its presence is known. We may find symptoms subjective, objective, direct and sympathetic; hence there is a necessity for thoroughness and uniformity. In speaking of advantages of adequate preparation and an orderly method, Prof. A. Reeves Jackson lays down a rule which I think is a very good one.

G. O. P. E. First.—*General Inspection.*
Second.—*Oral Interrogation.*
Third.—*Physical Examination.*
Fourth.—*Examination of Expelled Substances.*

Errors of diagnosis lead to errors of treatment. If physicians make a mistake in diagnosis (the first of a curative process which they are called upon to do), as a usual consequence their whole line of treatment is a mistake. But we must not satirize the doctors, for if we do we are complaining of human nature itself.

Their knowledge is small, because all human knowledge is small; and in all these years of progress, who can say that he has constructed a science of the human body or of the human mind? True is the complaint of the hero of "Locksley Hall," "Science moves but slowly, slowly creeping on from point to point." We cannot take up a periodical or medical book without seeing the absolute uncertainty that exists on what one would think the most elementary matters, the conflict of opinion on subjects that might have been settled long ago.

Every now and then a new case is placed upon medical record, the symptoms are published and brought up for discussion, and from everywhere come suggestions for the nomenclature or treatment. Perhaps the patient little thinks that her case has gone upon record, and that she is immortalized under some obscure initials. However, the discussion does the profession a great deal of good, even if it be a recapitulation of what a great many already know. Sometimes a point which has been heretofore overlooked is now brought to light. Here we may reflect credit upon scientists, who, like Agassiz, though laboring incessantly under difficulties, they do not complain; for in the service of truth they are content with having brought to light some new facts which will be a benefit to their fellow men.

Diagnosis should be carefully studied, and the *art* acquired by practice.

* By G. Jackson Tobias, M.D., Class 1884-5, College Physicians and Surgeons, Chicago.

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The scientific man abhors the empiric, still the latter has an art in manipulating which sometimes leave the trained professional skill in the despairing distance; this he must have acquired by practice (of course at the expense of his patients). How much better the world would be,—how much too of practical convenience in daily life would result, if all could know that everyone meant what he said and said what he thought.

I have a case now in mind, one of our dispensary patients, Mrs. H., whose condition, I am informed by Dr. Murdock, was diagnosed a few months ago by a homeopathic doctor as pregnant. A careful examination and a thorough knowledge of procedure could not, I think, have lead to this mistake. Not only a correct diagnosis should be made, but the object being accomplished, the same energetic power should be devoted to its alleviation and cure.

A somewhat interesting case came under observation at the dispensary last July; Mrs. C., 35 years of age, reached puberty at 14; had good health until married, two years ago; has had no children; menstruation every four weeks; flow scanty and free from pain. Patient says her husband struck her in the side eight or nine months ago (this accident having taken place sometime in June), which caused her considerable pain; subsequent to this she has noticed a slight swelling in the right iliac region. She was examined at that time by Dr. E. P. Murdock, gynecologist to the dispensary, who gives me the following notes: Uterus quite small, crowded somewhat to the left; cervix conical, cavity 2¼ inches deep; slight pelvic tenderness and a small rounded tumor in the region of the right ovary, about the size of a goose egg; this swelling evinces distinct fluctuation, and is pronounced an ovarian cyst. Ten days later the doctor called at her residence and tapped the cyst with a large-sized aspirating needle, securing about one ounce of clear, watery fluid. The needle became clogged, and upon removal was found to be filled with an oily, cheesy substance, of a light gray color; after renewing the effort at tapping several times, and always with the same result, the cheesy substance was examined under the microscope, and found to contain sebaceous matter, oil globules, and broken-down epithelium, proving it to be dermoid in character.

It is an art, a talent, a science, to observe critically, and from our observations to draw correct conclusions. Pathologists are still at variance with reference to the origin of ovarian cysts, some holding their origination from the follicles; some authors doubt this entirely, while others still, with Rindfliesh, admit two different sources of cystic formation, one being the follicles and the other the interstices of the stroma. Thomas, in his excellent work on Diseases of Women, says: "While pathologists are testing this question, we may for the time as-

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sume that there are two entirely different pathological processes by which true ovarian cysts are formed. First, the follicules become filled with coloid material, due to abnormal secretions from their walls, and, according to Rokitansky, probably the result of inflammation; or, second, a development of cysts may occur in the stroma of the ovary, without connection with the follicules. Billroth says, "cystomata of the ovary may be classified among the complicated cystic tumors, and in the great majority of cases there is a new development of gland follicles or ducts, from which terminal swellings become checked off; a fluid is secreted in these newly formed follicles which distend and sometimes become immense ovarian tumors." Now, as to the nature of the cyst, this we must determine from a thorough examination, and also an examination of expelled substances. As to surgical means of treatment, we have to resort to one or more methods, as tapping, drainage, incision, injection, etc. As regards the latter for ovarian cysts, unfortunately few are suited for this treatment, and extirpation of these tumors by laparotomy is considered the only certain operative proceeding.

Theory of the Menstrual Process.—Dr. Loewenthal has recently published in Leipzig a new theory to account for this peculiar physiological process, the salient points of which are given as follows (*N. Y. Med. Rec.*):

1. The periodical flow of blood from the genital organs of women is not in consequence of the (for most part coincident with) rupture of the Graafian follicle, but the result of the shedding of the mucous membrane lining the uterus, which is independent of the rupture of the vesicle, and takes place before it.

2. The formation of the menstrual decidua is due to the embedding of the very last ovum set free in an unfructified condition from the ovary.

3. It at once transforms itself into the decidua of pregnancy if the embedded ovum becomes fructified, but is shed in consequence of the death of the ovum if it remains unimpregnated.

4. During menstruation, the bursting of the vesicle and the menstrual bleeding have no other causal relation to one another than is to be found in the causes and conditions simultaneously present, affording a favorable opportunity for the bursting of a matured follicle.

5. The coincidence of the bursting of the vesicle and the flow of blood is consequently no necessary one, and either can appear independently of the other. A vesicle can burst without there being present at the time a decidua. The secondary consequence of the escaped ovum, i.e., the menstrual bleeding, can appear without a new vesicle bursting at the same time.

6. The periodicity of the menstrual flow is dependent upon the vitality

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which the ovum is capable of maintaining outside of the vesicle when embedded and remaining unfructified.

7. For impregnation to take place, an ovum usually freed from the vesicle at the time of the last menstruation must be always present, normally in the uterus, in abdominal cases somewhere outside of it.

These conclusions are based upon the supposition that ovulation is as regular as menstruation, since the menstrual flow is called "the secondary consequence of the escaped ovum," when in fact ovulation is not only very irregular, but may be absent for months and even years, and menstruation continue as regular as in any other case; again, it presupposes an active condition of the ovaries, the same as the old theories, when in fact menstruation has often been known to continue for years after both ovaries have been removed.

In fact the conclusions in this "new theory" are subject to the same objections as those of the old and generally accepted theory, when in fact neither have been proven. To deny the interdependence of menstruation and ovulation does not necessarily imply that we must furnish a theory on the contrary; it is but proper in all scientific men to reject or disregard all theories until proved.

Better say with Lawson Tait, "this is an inconvenient physiological process, the causes or benefits of which no one has ever yet been able to determine or explain; the fact is, we know but little about that peculiar function, menstruation, and we just as well say so until we gain more definite information."

Pregnancy at Fifty-one Years.—Dr. F. N. Burgess reports a case of a woman aged 51 years, 3 months and 10 days. This reminds the editor of a case in his own practice; patient 50 years of age gave birth to a healthy boy, and informed the doctor that she had a grand-daughter married, and expressed a hope that he would attend her in her first confinement. In contradistinction to this, Dr. McDermott, of Cowden, Ill., reports a case in his practice, a girl, 11 years, 10 months and 6 days, giving birth to a healthy child. He calls it "precocious fecundation."

Puerperal Cardiac Thrombosis; Death.—The extreme interest that attaches to this frightful accident or incident, its sudden and unexpected appearance at times, and the almost certain fatality, prompts me to give the notes from two fatal cases coming under my own observation, with the diverse physical conditions of the patients treated.

1st. Mrs. R. age 23, a farmer's daughter, having been in the city but a few months, medium height, strong build, full habit, and every appearance of perfect health; married one year; first pregnancy; suffered but little inconvenience during gestation, and was well able to attend to her household affairs up to the day of her confinement. Nothing in family or per-

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sonal history to excite suspicion. Sept. 12, '84, I was called to attend her in confinement; arrived at 9.30 a.m.; found os well dilated, pains vigorous, labor progressing nicely, and in less than an hour it terminated favorably; fifteen minutes later placenta and membranes were expelled intact, and patient was quite comfortable. I saw her again in the evening of the same day, and she expressed a desire to sit up and have her supper. Hemorrhage had been moderate and everything indicated her speedy recovery. I saw her again 24 hours later, and heard a very favorable report. About midnight that night I was called with the word that she was dying. I found her propped up in bed, having a wild, frightened expression on her face, and complained of great weakness and dyspnœa; pulse 130, temperature 97° F., and inability to lie down. The heart sounds were feeble and tumultuous; respiration short and gasping, and a constant dread of dying. I immediately diagnosed cardiac thrombosis, and gave a very unfavorable prognosis. Dr. I. N. Danforth was called later in the night, and found the conditions somewhat changed but not improved; the tumultuous action of the heart had given way to a feebler and more rapid action, registering 200 per minute; increased dullness or rather flatness over the lung, and temperature 102° F., rising rapidly. He confirmed the diagnosis, except that he gave it as his opinion that the clot or clots had been carried into the lung and produced pulmonary embolism. Stimulants were administered freely, but she died at 8 next morning. No post-mortem.

2. Mrs. T. C., age 33, married one year, first pregnancy. I was called to see her husband, suffering from inflammatory rheumatism, and incidentally was asked to see Mrs. C., and to have her attended as an outside patient to the West Side Free Dispensary. Upon examination I found her very weak, anæmic, limbs enormously œdematous, pulse weak, rapid; heart-beat faint and a marked friction murmur over the base or tricuspid valves. Urine showed about 30 per cent albumen. I orded digitalis, ext. humulus and liq. ammon. acetatas, but saw her no more until called to attend her in labor. Being very busy, I called Dr. Fliesberg to assist me, and left her in his charge. I returned at 1 p.m., just in time to see him deliver her of twins, two strong healthy boys. The labor had been easy, secundi easily removed, but the hemorrhage was very profuse. I saw her again in the evening and found her nearly exsanguinated, face swollen, complexion deadly waxy, and complaining of extreme faintness, ordered stimulants to be given freely. She urinated freely and rested fairly that night. I saw her again the third day, when she complained of great difficulty in breathing; pulse weak, 130 per minute, but otherwise cheerful. Within an hour of my visit she was startled by a feeling of some impending danger, and insisted that she was dying,

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whereupon the friends called Dr. Van Buren who lived very near. He found her in a state of extreme terror; pulse impercepitble at the wrist, heart-beat labored, tumultuous; great dyspnœa, and extreme prostration, and in less than an hour she died. Post-mortem twenty-four hours after death, heart only examined. Heart walls pale, thin and fragile; endocardium roughened, right ventricle contained a large clot, white, dense, firm on surface, clinging to the tricuspid valves and extending into the pulmonary artery. Were not permitted to examine the kidneys.—*E. P. Murdock, M.D.*

—Dr. W. E. Rodgers, (*Albany Medical Annals*), who has never lost a case in confinement in thirty-seven year's practice, (lucky man), attributes a great deal of his good fortune to the use of a vectis. He never goes to a labor case without instruments; during the labor when the pains are good, but the head is not in just *the* position to glide along the oblique diameter of the pelvis easily, he slips the vectis under the side of the head, lifts into proper place, and then with a little traction, brings about the delivery speedily. When the pains are inefficient he gives small doses of macrotin at intervals of fifteen minutes. He says that, "In an incredible short time the labor is accomplished *cito, tuto et jucunde.*" His record is certainly remarkable to say the least.

Eye and Ear.

Edited by J. E. HARPER, M.D., 163 State St.

[We are indebted to Wm. D. Babcock, M.D., Evansville, Ind., for the following original and selected matter, coming under the above heading.]

Keratitis and Chronic Syphilitic Iritis.—Dr. Parinaud, of Paris, declares that an examination of twenty-three cases of parenchymatous keratitis observed by him, shows that this affection is especially apt to occur in children who were conceived when the syphilis of the parents was already old, and that it was consequently an expression of attenuated syphilis of the parents. It is probably not a lesion directly syphilitic * * but an indirect product of syphilis.—*L. Brocq, Jour. Cutan. and Vener. Diseases, Feb'y, 1885.*

Granular Lids. Treatment.—Dr. Wm. F. Mittendorf, of New York City, finds in the first stages of granular lids, the metallic astringents indicated, such as nitriate of silver, sulphate of copper, etc. In the second class, balsam of copabia, muriate of hydrastin, tannin and jequirity; especially balsam of copaiba diluted with nine parts of vaseline. If there is

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much swelling of the conjunctiva, then the hydrastin. This is painful. All painful applications should be preceded by use of cocaine.

Ear Ache.—We see recommended various liniments and ointments for the relief of ear ache. Either one of the following will relieve forty-five out of fifty cases, and should be used first in the order given: Solution muriate of cocaine, hot water and leeches; the water can be heated in a spoon over a lamp, and poured in the ear every few minutes. Dr. Miot quoted in *Therapeutic Gazette*, recommends highly atropine in acute otitis and rhinitis in children. It is particularly valuable in aborting coryza, thus preventing the spread of the inflammation to the Eustachian tubes. He gives about $\frac{1}{500}$ of a grain every three hours for three days.

Treatment of Wounds of the Sclerotic by Suture.—Simeon Sneel, ophthalmic surgeon, in the *Ophthalmic Review*, Oct. 1884, in an account of a case of a wound in the sclerotic, says "previous experience had taught me the extreme utility of uniting wounds of the sclerotic by suture, even in apparently hopeless cases." A needle threaded with fine gut was therefore passed well under the divided conjunctiva on either side of the scleral wound and then tied tightly. Atropine was ordered to be dropped into the eye twice daily, and a pad of lint, wetted, was placed over it. He prefers gut for a suture, but has used silk and platinum. Two points contribute to the successful treatment of these cases, viz.: That they should be treated * * * very soon after accident, and that the wound should be a clean one.

Severe Conjunctivitis from Whiskey Thrown Into the Eyes.—Mr. G. A. Brown, *British Med. Journal*, March 22, 1884, reports seeing the patient the day after whiskey had been thrown in his eyes. Both eyes were closed, lids much swollen with yellow sanious semi-purulent discharge. The lower half of each cornea was covered by a diphtheritic membrane, which peeled off, leaving cornea clear, the conjunctivæ were deeply injected, no chemosis. There was much pain and intolerance of light. Under belladonna fomentations and syringing with a weak warm solution of boracic acid, improvement rapidly took place. In two days the membrane had disappeared, and the conjunctivitis and photophobia soon subsided; in two weeks it was well.

Chancre of Eyebrow.—Mr. G. K. Thorpe reports a patient with an indurated sore at the outer side of left eyebrow. The chancre had nearly healed. There were secondary symptoms.—*Brit. Med. Jour., April, 1884.*

Politzerisation.—The following hints are given by H. Macnaughton Jones to practitioners when adopting Politzer's method:

1. Let the patient be seated.

2. Incline the head to one side, and try inflation through either nostril; do this for both ears.

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3. Direct the current as horizontally as possible.

4. Experimentally ascertain whether any form of nasal phonation, or the act of deglutition, best dilates the aperture of the tube. Adopt this method with the individual patient.

5. If phonation compress during the pronunciation; if deglutition observe, while the head is inclined, the elevation of the larynx, and compress the bag just at the commencement of its ascent.

6. In children, phonation is the best act to take advantage of, but direct inflation through the naso-pharynx may be sufficient. We can always inflate when the child cries.

Eye and Dental Irritation.—Mr. Henry Powers, in a paper "on the relations between dental lesions and diseases of the eye," lays it down as a maxim to be generally observed, that in all cases of threatening glaucoma, especially when this is associated with ciliary neurosis and obscure pains in the temples and maxillary regions; in all cases of mydriasis, and probably of myosis, originating without apparent causes; in all cases of sudden paralysis of either of the orbital muscles, or of loss of sensation in the absence of cerebral symptoms; in all cases of phlyctenular diseases of the conjunctiva; in all cases of ulcers of the cornea resisting ordinary treatment; in all cases of sudden failure of accommodation, especially in young children; and, finally in cases of exophthalmia, the condition of the teeth should at least be examined, and if diseased, removed, and then one, at least, of the possible causes removed.—*Trans. Odont. Soc., Nov. 1883.*

Treatment of Purulent Otitis by Boroglyceride.—Brandeis recommends the use of boroglyceride in purulent chronic troubles of middle ear, especially where there are polypoid growths and granulations in the tympanic cavity. The ear is thoroughly cleansed, eight to ten drops of a seventy-five per cent. solution of boroglyceride is dropped into the meatus, (a better way would be to apply with cotton? B); after this a few drops of collodion are put into the ear, which, in a few minutes, forms a membrane of the glyceride. This may remain intact for a week (the Eustachian tube should be open. B.)—*Tangeman, in Lancet and Clinic.*

Editorial.

The College of Physicians and Surgeons, Chicago.—The third annual session of this institution closed March 10, 1885. The commencement exercises were held at the Grand Opera House, beginning at 2.30 p.m.; Dr. Henry L. Raymer, of the graduating class, delivered the valedictory, and an address on the "Disposal of the Dead;" Prof. J. J. M. Angear delivered the doctorate address on "Our Mission." Both

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addresses were able and instructive, and we regret a lack of space prevents our publishing them in full. Sixty gentlemen of the senior class were reported by the secretary as having successfully passed the examination for the degree of M.D. Four of the graduates, Geo. H. Harkness, W. C. Caldwell, T. A. Davis and W. Van Hook, had been successful in the competitive examination for the position of Internes at the Cook County Hospital; one, Jas. B. Eagleson, at the Marine Hospital, and one, N. H. Pierce, at St. Luke's Hospital. The secretary, on behalf of the faculty, congratulated the class on this marked evidence of superior attainments in their studies.

The Hutton prize for the best examination in diseases of the mind and nervous system was equally divided between Wm. E. Allen, of the graduating class, and W. W. Kane, of the second year.

The Alumni banquet was held in the evening at the Sherman House. A large number of former graduates were present, and a very enjoyable time was spent in feasting and responding to toasts.

The meeting of the Alumni Association was held in the college building at 10 a.m., and was well attended. The Historian, Dr. C. B. Horrell, of Colchester, Ill., read a very interesting and flattering report of the success attained by many of the alumni.

Books.

THE STUDENT'S MANUAL OF HISTOLOGY FOR THE USE OF STUDENTS, PRACTITIONERS AND MICROSCOPISTS. Third edition, entirely re-written, greatly enlarged, and newly illustrated.—By Charles H. Stowell, M.D., F.R.M.S. Professor of Histology and Microscopy, and in charge of the Histological Laboratory of the University of Michigan. Illustrated by 178 engravings. Ann Arbor, Mich.: Charles H. Stowell, Publisher, 1884.

The text of this valuable book has been entirely re-written and a large amount of new matter added; many of the illustrations used in former editions have been replaced by new cuts, and new figures added to illustrate important points. We cannot better indicate our high appreciation of Dr. Stowell's book, than to quote from a review of the previous edition in the REPORTER: "It is not the less valuable to those who have not the time to spare from professional labor to first master a microscope, and then carry out in detail an investigation. This manual has done the work so well, that all one need to do to make himself a fair histologist is to examine the numerous plates in conjunction with appended well written texts. One supreme advantage this manual has over most works of a

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like compass, is that each tissue is not only well illustrated, but the student is told just how to prepare them for the microscope, *so that he may know just what he sees in looking at the object.* This will be appreciated by all those who have had to master the different parts of the economy without the well arranged aids here presented."

INSOMNIA AND OTHER DISORDERS OF SLEEP.—By Henry M. Lyman, A.M., M.D., Professor of Physiology, and of Diseases of the Nervous system, Rush Medical College, Professor of Theory and Practice of Medicine, in the Woman's Medical College, Chicago, etc.: Published by W. T. Keener, 96 Washington Street, Chicago, 1885.

The subject matter of this book is divided into seven chapters, as follows: The nature and cause of Sleep; Insomnia or Wakefulness; Remedies for Insomnia; Treatment of Insomnia in particular diseases; Dreams; Somnambulism; Artificial Somnambulism or Hypnotism. Professor Lyman is both a graceful and lucid writer, and he has succeeded in presenting a comprehensive resume combined with new and original matter. The value of the book is greatly enhanced by the addition of a complete index.

We believe it to be a book that will be appreciated and sought after by the majority of the profession.

THE LONDON MEDICAL STUDENT AND OTHER COMICALITIES:—Selected and compiled by Hugo Erichsen, M.D., recently Professor of Neurology in the Quincy School of Medicine, Medical Department of Chaddock College, etc.: Detroit, Michigan, Hugo Erichsen, Publisher, 11 Farmer street. Price $2.00

As the author of "Medical Rhymes" Dr. Erichsen has shown himself to be a successful caterer to the comedy-loving element of the profession. This, his latest production is a compilation of humorous matter skilfully arranged, and is an excellent book for diverting the overtaxed mind of the busy Practitioner into pleasant and relaxing channels.

—THE THIRD edition of Dr. D.W. Cathell's excellent little work, the "Physician Himself," has been exhausted, and the fourth edition, greatly enlarged and improved, is in press. We congratulate Dr. Cathell on his well-merited success.

Journal de L'Anatomie et de La Physiologie Normales et Pathologiques De L'Homme et Des Animaux.—Publié par MM. Charles Robin, Professeur a Faculté de médecine de Paris, et G. Pouchet, Professeur au Muséum d'histoire naturelle de Paris. 21e Année (1885.)

Ce journal paraît tous les deux mois et contient: 1° Des *travaux originaux* sur les divers sujets que comporte son titre; 2° l'*analyse* et l'*appréciation* des travaux présentés aux Sociétés francaises et étrangères; 3° une *revue* des publications qui se font à l'étranger sur la plupart des sujets qu'embrasse le titre de ce recueil.

Il a en outre pour objet; la *tératologie*, la *chimie organique*, l'*hygiène*, la *toxicologie* et la *médecine légale* dans leurs rapports avec l'anatomie et la physiologie ;

Les application de l'anatomie et de la physiologie à la *pratique de la médecine, de la chirurgie et de l'obsterique.*

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Medicine.

Edited by WM. E. QUINE, M.D., 3151 Wabash Ave.

On the Sources and the Excretion of Carbonic Acid in the Economy.— Not many years ago, it was a general belief among physiologists that the generation of carbonic acid occurred chiefly in the lungs, owing to the direct oxidation of part of the carbon contained in the blood; and, accordingly, the lungs were regarded as the chief, if not the sole, centre for the production of the animal heat. Respiration, in fact, was described as a combustion-process occurring in the lungs, a process with which the rest of the body was not in any way directly concerned, except, perhaps, in supplying to the blood some of its effete carbonaceous material to be burnt up in the course of respiratory oxidation. Chemical and physical investigations, however, have caused this view to be discarded. It has been found, for example, that the venous blood going to the lungs contains a large quantity of carbonic acid, and is absolutely warmer than the blood leaving the lungs, as has been proved in the case of the blood in the right and left side of the heart respectively; the blood, moreover, which leaves the liver and other glands when in a state of activity, has been shown not only to possess a higher temperature, but also to be richer in carbonic acid than the blood entering these organs.

In short, the temperature of the blood, according to Claude Bernard's and Korner's observations, is highest in the liver, that of the blood in the hepatic vein being, on an average, 0.7 degrees Cent. to 0.9 degrees Cent. higher than that in the portal vein; and the next highest temperatures have been noted in the blood flowing respectively from the brain, the salivary glands, and the muscles, particularly when these parts are in

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an active condition. It is true that Heidenhain (*Physiologie*, von Dr. L. Hermann, Band v, theil 1, s. 274) has arrived at results differing somewhat from those of Bernard, for he finds that the blood of the liver has a temperature not exceeding that of the blood of the spleen, or of other abdominal viscera; yet there is no doubt about the temperature of the blood from the liver being high as compared with that of the blood from the lungs, muscles, etc.

What, no doubt, has greatly tended to direct so much attention to the importance of the tissues in respiration, has been the result of the investigations of the properties of protoplasm in the simplest forms of animal life. The primitive amœba has been shown to absorb oxygen, and give out carbonic acid; and the natural inference is, that all tissues containing protoplasm act after a somewhat similar fashion. The closest attention has, therefore, been directed of late to the minute chemical changes occurring at the tissues themselves; and, accordingly, we find Liebig, Matteucc, Valentin, and Hermann pursuing their investigations directly upon living muscles that had been removed from the animal body, and inclosed in tubes inverted over mercury; Ludwig and Schmidt analyzing the blood before and after it had passed through the living and active muscles of the animal so as to detect its alterations; and Hammarsten investigating the gases of the lymph with the same object in view.

In the case of secreting glands, likewise, observations have been made upon their recent secretions, as well as upon the changes effected in the blood during its passage through them. The saliva, bile, urine, and the like normal fluids result directly from the action of the histological elements of the secreting tissues, and are, therefore, more immediately influenced thereby than can be the lymph or blood flowing through the same tissues; but by investigations on the secretions, as well as on the lymph and blood of the tissues, we obtain not only the quantity of the gases in the tissues, but likewise their tensions.

The importance, indeed, of these investigations into the gases of the secretions is very great; for, by their means, much light is thrown upon the seats of the oxidation processes in the economy. By a very simple experiment an example of this oxidation, with the concurrent disappearance of oxygen, and the possible formation of carbonic acid, may be satisfactorily demonstrated. If we examine with a spectroscope, in a dark room, the red colored light that passes between two of the fingers held together in front of a good lamp, the spectrum of oxyhæmoglobin will show itself. If, however, we apply a ligature to the fingers close to the palm, in order to prevent the entrance of fresh arterial blood, and exam-

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ine as before, instead of the two bands of oxyhæmoglobin, there will be seen, in the course of a few minutes, only the single band of reduced hæmoglobin.

I. Sources of Carbonic Acid.—With these preliminary remarks, we may now discuss the possible *sources of carbonic acid* in the organism. Some of the better known of these we shall merely glance at in passing; others, however, which are less familiar, as well as of a more hypothetical character, we shall consider at greater length.

1. The chief source of carbonic acid in the organism, beyond all question, is *simple oxidation*, in which more or less combination occurs between the absorbed oxygen and the carbon of the food and tissues. The fatty matter of the food which is not stored up or directly consumed by the tissues requiring it, is ultimately transformed into carbonic acid and water, just as the like destination awaits the stored up fat of adipose tissue when it comes to be oxidized in the system. The carbo-hydrates (starches and sugars) taken as food, give origin likewise, when oxidized, to carbonic acid and water, although it is difficult to say whether these terminal products are direct or indirect. Indeed, there may be intermediate products, as in the case of the sugar-aceton sometimes appearing in the urine in cases of diabetes and continued fever; or glycosates may first be formed in the blood, and afterwards undergo complete oxidation. That some of these carbo-hydrates are oxidized during muscular activity, thus effecting a large production of carbonic acid, is also a very reasonable hypothesis. The proteids, further, may give rise to carbonic acid as the result of oxidation; but it is more probable that a direct complete metamorphosis of this kind takes place only to a very slight extent. As to the two views held regarding the part played by the albumen of the food: whether a portion of it enters at once into the constituion of the tissues while the rest circulates for a time in the blood, forming there unstable and readily destructible combinations; or whether the whole of it becomes tissue-albumen before undergoing subsequent metabolism; it would seem, without entering on a critical discussion of their respective merits, that the latter is the more likely; for the great increase in the amount of urea excreted after food, a fact which appears to be in favor of the former hypothesis, may be readily explained on the very probable assumption that the leucin and tyrosin, formed at the expense of the albumen in the alimentary canal, are absorbed, and thus form the immediate source, together, possibly, with kreatin, of the bulk of the urea then discharged.

Mention may also be made of Bidder's and Schmidt's opinion, that the

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albumen of organs is regularly destroyed at the rate of about one per cent. of the total albumen of the body in the twenty-four hours; and that in cases of death from starvation, when the glands and muscles have lost 50 per cent. of their albumen, some of it has been oxidized at the tissues, and some of it liquefied and transferred to other parts of the body, as the brain, etc., for their nourishment.

Reference may likewise, with advantage, be here made to the respiratory exchanges which occur when certain tissues, such as muscle, brain, and bone, are placed in an atmosphere of oxygen. We find, then, that 100 grammes of muscle absorb 50 c. c. of oxygen, and exhale 56 c. c. of carbonic acid; 100 grammes of brain absorb 45 c. c. of oxygen, and exhale 42 c. c. of carbonic acid; and 100 grammes of bone absorb 17 c. c. of oxygen, and exhales 8 c. c. of carbonic acid. The consumption of oxygen and the evolution of carbonic acid, it will thus be seen, are highest in the case of muscle.

As to the influences regulating this destruction of the organic materials of the body, Hoppe-Seyler states that they appear to be intimately connected with the activity of the histological elements of the organs; but whether they are of the nature of fermentation or otherwise, it would, for the present, be impossible to say.

2. The second source of carbonic acid in the system is *the decomposition of albumen by hydration or dehydration.* In a paper (*Journal of Anatomy and Physiology*, 1882, p. 298) "On the Gases of the Bile," which I published in 1882, I put forward an hypothesis as to the probable mode in which albumen might by its decomposition at the liver produce carbonic acid. I there assumed that a molecule of albumen might be supposed to combine with 50 molecules of water, and yield 8 molecules of urea, 7 of glycogen, 5 of carbonic acid, 7 of oxygen, and 1 of sulphuric acid. The oxygen would not, of course, remain free, but might enter into combination with reduced hæmoglobin or other substances. In favor of this assumption, it should be remembered that, of the 18 atoms of nitrogen in a molecule of albumen ($C_{72}H_{112}N_{18}O_{22}S$), 4 probably belong to the urea group; and also that carbonic acid has actually been obtained in the laboratory from albumen.

Schützenberger had, a few years previously, advanced an hypothesis somewhat similar to mine, although I was not aware of it at the time of the publication of my paper. He assumes that 100 grammes of albumen generate first 35.5 grammes of urea, and the residue, by subsequently combining with 12.3 grammes of water, gives origin to 27.4 grammes of carbonic acid, and 51.39 grammes of fat. He has further shown that

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albumen may be decomposed into carbonic acid, ammonia, oxalic and acetic acids, and that the ratio of carbonic acid and ammonia to each other is the same as if urea had been made the basis of experiment. He also believes that the carbonic acid and ammonia may afterward combine in the body under the influence of electrical currents, and thus form urea, dehydration having taken place at the same time. If this view prove correct, some of the carbonic acid evolved in the liver would not leave that organ as such, either by the blood or bile, and would not, therefore, appear at the inner or the outer surface of the body in the gaseous form. We can readily believe in the albumen of the tissues, particularly the muscular and the nervous, undergoing these chemical changes during its metabolism, and so account for the carbonic acid present in all the tissues, and for the urea found in some of them; but it is, moreover, probable that a part, at least, of the primary decomposition products of the albumen may be yielded up by the tissues to the blood, and thus conveyed directly to the liver, where the decompositions above described may ensue. That chemical changes, such as oxidations and decompositions, occur to a large extent at the liver, is indicated by the high temperature of the blood of the hepatic vein, as well as by the great quantity of carbonic acid in the bile. In fact there can be no doubt that the destruction of albuminous material is most active at the liver, for this organ, as we know, contains about a fourth of the total blood of the body;—an amount equal, indeed, to that in the muscular system, although this system constitutes at least half the normal body weight; besides, there are to be found in the liver a great number of nitrogenous substances, intermediate between albumen and urea, such as leucin, tyrosin, xanthin, hypoxanthin, uric acid, etc. According to the most authorities, also, there is more urea to be met with in this organ than in any other in the body, many physiologists even believing that the bulk of the urea is formed here. The urea certainly cannot be derived from the blood by a mere process of filtration into the liver; for the nervous and muscular tissues, which do not directly produce urea, contain little or none of it.

Not only, however, may albumen be decomposed at the liver and produce carbonic acid, but there are good grounds for believing that the crystalline indifferent proteid—hæmoglobin, which is a higher albumen derivative, is broken up in the liver into a number of simpler bodies—an hypothesis advanced by Dr. Zuelzer of Berlin. (*Untersuchungen uber die Semeiologie der Harns*, Berlin, 1884.) The following equation expresses the decomposition—2 hæmogoblin ($=C_{1200}H_{1920}N_{308}Fe_2S_6O_{356}$) $\times$ 85 H_2O $\times$ 123 O – Fe_2O_3 =

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	C	H	N	O	S
6 Taurocholic acid..	156	270	6	42	6
24 Glycocholic acid..	624	1032	24	144	—
2 Bilirubin	64	72	8	12	—
135 Urea.....	135	540	270	135	—
4 Cholesterin.....	108	176	—	4	—
113 Carbonic acid.....	113	—	—	226	—
	1200	2090	308	563	6

[The fact that the use of albuminous food increases the amount of biliary acids formed at the liver, tells somewhat in favor of this hypothesis.]

Or, 13.332 grammes of hæmoglobin, with the necessary water and oxygen, yield 2.486 grammes of carbonic acid. A further decomposition of a smaller proportion of hæmoglobin with the formation of glycogen (taking glycogen as $C_{30} H_{50} O_{25}$; Schtscherbakoff) is aloo probable. Thus 2 hæmoglobin ($=C_{1200} H_{1220} N_{308} Fe_2 S_6 O_{358}$) × 501 O × 182 H_2O– $Fe_2 O_3$ × 6 $H_2 So_4$ =

	C	H	N	O
2 Bilirubin.....	64	72	8	12
150 Urea.....	150	600	300	150
32 Glycogen.....	960	1600	—	800
26 Carbonic acid...	26	—	—	52
	1200	2272	308	1014

Or 13.332 grammes of hæmoglobin yield 0.572 grammes of carbonic acid, and 12.96 grammes of glycogen.

Owing to the destruction of red blood-corpuscles which is constantly occurring in the spleen, a considerable quantity of hæmoglobin in solution is as constantly being carried to the liver; and if this be borne in mind, it will readily be perceived that the amount thus disposed of is far from inconsiderable. Moreover, red blood-corpuscles are also broken up at the liver; for glycogen, as Hoffman has pointed out, dissolves them. To give an idea of the rate at which old red corpuscles are destroyed, and hæmoglobin at the same time set free, I may mention that a calculation has been made which indicates that the duration of the life of a red corpuscle is at most about thirty days. Thus, taking the amount of iron in all the corpuscles of the body as one gramme, and the quantity excreted in twenty-four hours as 35 milligrammes, all the iron would be eliminated from the body in thirty days; for $\frac{1}{0.035} = 30$ days.

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Now whilst it must be admitted that some of the chemical changes I have described as taking place at the liver are to a great extent hypothetical; yet there can be little doubt that, as Heidenhain and others suppose, albumen in some form is decomposed in the cells of that organ, and biliary acids and pigments formed in the same cells as the glycogen. It is true that these two processes in the liver, resulting in the formation of glycogen and bile, though both are attended by a corresponding production of carbonic acid, differ markedly in that their periods of intensity do not synchronise; and, further, in that, whilst the biliary secretion continues during starvation, the formation of glycogen ceases. The secretion of bile, indeed, does not depend on the pressure of the blood; for the pressure under which it is secreted exceeds that of the blood in the liver, although the amount formed is influenced to a certain extent by its velocity and pressure, because with increased velocity and pressure of the blood, more albumen is brought in a given time to the liver to undergo metamorphosis.

II. Seats of Excretion of Carbonic Acid.—It has been computed that nine-tenths of the carbonic acid eliminated by the body passes off by the lungs, and the remaining tenth by the intestines, skin, and kidneys.

1. *The Lungs.*—About 900 grammes of carbonic acid, on an average, leave the body in the twenty-four hours by the lungs; that is, an amount of carbonic acid equivalent to 249 grammes (or 8 ounces) of solid carbon. This discharge of carbonic acid is chiefly due to diffusion, the tension of the carbonic acid in the venous blood being greater than that of the carbonic acid in the air of the air-cells. Of every five parts exhaled, one part is possibly derived from the blood-corpuscles, and the other four from the liquor sanguinis. In the corpuscles, there is probably some loose combination between the carbonic acid and the hæmoglobin; but in the liquor sanguinis, it is partly in solution and partly combined with sodic phosphate and carbonate.[1] Simple diffusion, however, is of itself scarcely sufficient to account for the total discharge, for we must also bear in mind that the gas is in a state of solution in its passage through the moist capillary walls and the epithelial lining of the air-cells. Further, the entrance of oxygen undoubtedly increases the tension of the gas in the blood, a fact which has been pointed out by Holmgren.

2. *The Skin.*—An average of nearly four grammes of carbonic acid

1. Carbonic acid may likewise be united to paraglobulin in the red corpuscles. Setschenow believes that the colorless corpuscles also fix carbonic acid, their absorbing power for this gas being 1-12th that of serum.

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is discharged by the skin in the twenty-four hours—that is, about 1-200th of the amount excreted by the lungs. The gas is exhaled from the sudoriferous glands, and partly also from the surface of the skin itself.

3. *The Secretoins.*—I have already referred to the light which a full knowledge of the gaseous conditions of the secretions throws upon the respiratory interchanges at the tissues. Indeed, more is to be learnt from the study of the gases of the secretions even than from that of the gaseous exchanges, at the tissues, of either the blood or the lymph; for the secretions have been more directly in contact with the elements of the gland tissues—being as it were part of the tissues themselves, and hence the importance of investigations in this direction.

The tension of carbonic acid in the cavities and liquids of the body, when these are surrounded on all sides by healthy tissues (as in the case of the bile in the gall-bladder and the urine in the urinary bladder) is greater than that of the carbonic acid in venous blood.[2] The tension of the gases in the tissues is determined indirectly from the tension of the gases in the lymph or in the secretions; but the latter mode is to be preferred, for in lymph the carbonic acid tension is less than in venous blood, partly owing to gaseous diffusion between the arterial blood and the lymph, where the vessels containing them are in close proximity—an objection, however, which does not apply in the case of the secretions.

The secretions, as a rule, are formed in the interior of cells, either directly from their own protoplasm, or by the agency of the latter from materials derived from the blood. The phenomena of secretion are accompanied by the disengagement of heat, readily demonstrable by means of the thermo-electric needle, both in the blood and in the secretion formed.

Of these secretions, we shall first consider—

a. The Bile.—In this secretion, collected directly as it flowed from the liver of the dog, I found, in a series of experiments I made about two years ago in Bonn, a total of 57 volumes per cent. of carbonic acid,[3] 14 per cent. of which was evolved *in vacuo*, while the remaining 41.7 per cent. required the previous addition of phosphoric acid to disengage it; whereas of oxygen and nitrogen there were only traces. That this proportion of carbonic acid is very large can readily be understood, when it is stated that there are only 34 volumes per cent. of the gas present in the arterial blood of the dog, and 46 volumes per cent. in the venous blood of

2. Tension of carbonic acid in arterial blood, 21.28 mm. of mercury; venous blood 41.0; bile, 50.0; acid urine, 68.0; hydrocele fluid, 46.5; fluid of peritoneal cavity, 58.5; lymph, 35 5.

3 In this experiment, as in almost all referred to in this paper, the volume of the gas is given at a pressure of one metre, and a temperature of 0° C.

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the same animal. The tension of these gases in the bile of the dog, as taken from the gall-bladder (for I am not aware that the tension has been determined in the case of freshly secreted bile), is comparatively low—only equal to 50 mm. of mercury; but then it should be recollected that the tension of carbonic acid in venous blood is only equal to 41 mm.; the blood-pressure also in the portal vein is very low, perhaps not more than 10 mm. From the bile of the rabbit (the only herbivorous animal in which freshly secreted bile has up to the present been examined) I obtained a total of 109 volumes per cent. of carbonic acid, free and combined—a larger proportion than has yet been discovered in the fluids of any animal, but only slight traces of oxygen and nitrogen.

With regard to the possible source of the large amount of carbonic acid excreted at the liver, two views suggest themselves: (*a*) that the carbonic acid is produced in the different tissues and organs of the body, the liver included, and some of it then passes out by simple diffusion or solution from the portal and hepatic capillaries into the bile (as may occur at the pleura in lymph exudations), the hepatic cells not being specially concerned in the process; (*b*) that, in addition to this *general* formation of carbonic acid in the body, there is a *special* production of the gas at the liver, owing to the decomposition in the hepatic cells of such bodies as albumen and hæmoglobin. I have already given reasons in support of the latter hypothesis. Of the carbonic acid thus generated in the liver, part will enter the blood and a larger proportion the bile, particularly if this fluid is alkaline; just as the carbonic acid formed in the tissues passes off from them in the lymph and in the venous blood, but a greater proportion in the latter, because it exercises a stronger chemical attraction for carbonic acid.

The amount of combined carbonic acid in animal fluids or secretions depends, as a rule, on their reaction, whether alkaline, acid, or neutral. If the secretion be alkaline, more of the tissue carbonic acid will leave the body by that fluid than by one less alkaline; while, if neutral, or particularly if acid, scarcely any combined carbonic acid will be found in it, as compared with the total carbonic acid in the blood. A good example of this can be observed in the case of bile. If the bile of a dog is alkaline, as it is usually, 100 volumes may contain 57 volumes of carbonic acid; while, if acid, there may be in 100 volumes only 5 volumes of the same gas. Urine, again, which is acid, contains only 14 volumes per cent. of carbonic acid; while, in alkaline saliva, there may be present as much as 50 volumes per cent. But, in herbivorous animals, in which the bile is more alkaline than in carnivorous, there is a proportionately larger

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amount of carbonic acid, and this greater richness in the gas may be the case, as well, with the other fluids of these animals, though this has not yet been determined.

Accordingly, from the proportion of carbonic acid in the bile, it would be unsafe to estimate the total amount of carbonic acid generated in the liver; for, if the bile formed be less alkaline than the blood flowing away from the liver, the greater part of the carbonic acid will probably be conveyed away by its means to be excreted elsewhere. I am not aware that any experiments have been made as to the relative quantities of the carbonic acid in the blood of the portal and hepatic veins, an exact knowledge of which would be most useful in our present inquiry; and without it, I do not feel myself in a position to say more on this subject.

b. The Urine.—The presence of sodic phosphate and carbonate in the urine renders it capable of dissolving carbonic acid. Pfluger found that 100 vols. of urine yielded of free carbonic acid 17 volumes and of fixed carbonic acid set free by phosphoric acid, 0.2 volume. Some of this carbonic acid is probably formed by the cells of the kidney, because nitrogenous metabolism occurs here; but the larger proportion is possibly excreted in solution in the fluid discharged at the Malpighian capsules. An interchange of gases likewise goes on in the tubes of the kidney. The tension of the carbonic acid in the urine is higher than that in the bile, being equal to 68 mm. of mercury.

c. The Saliva.—The submaxillary saliva of a dog fed on flesh-meat yielded Pfluger 19 volumes per cent. of free carbonic acid, and 30 volumes per cent. of carbonic acid evolved on the addition of phosphoric acid—that is, about 50 volumes per cent. of the gas, free and combined; and when the animal was fed on a mixed diet, the total volume of carbonic acid was considerably greater. In its richness in carbonic acid we, therefore, notice that this secretion approaches bile closely, but if the small volume of the submaxillary saliva be taken into account, it wil readily be perceived that, as compared with bile, only a small proportion of the carbonic acid is thus discharged.

d. The Milk.—This fluid, according to Pfluger, contains 7 per cent. of free and combined carbonic acid.

e. The Pancreatic Juice.—The amount of carbonic acid in this secretion has not yet been ascertained.

f. The Intestinal Secretions.—It is impossible to say what proportion of the gases in the alimentary canal is derived from the blood by diffusion, what from the air swallowed, and what from the fermentation and decomposition of the intestinal contents. As Planer's researches have

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shown, the nature of the diet affects the composition of the gases in the intestines. Carbonic acid is always present in large amount. A gaseous interchange between the intestinal contents and the blood very probably occurs, for in many animals (the air-swallowing fish, *cobitis fossilis*, for example: intestinal respiration appears to be important.

g. The Normal and Abnormal Exudations.—Reference may be made, in conclusion, to the carbonic acid in these liquids. They resemble dilute liquor sanguinis in composition, and may or may not be spontaneously coagulable; but they are always alkaline, and, therefore, capable of retaining much carbonic acid in solution. The gas is derived from the tissues by means of the lymph poured out into the serous or other cavity, or it leaves the blood in a state of solution, and accumulates according to the solvent or fixing-power of the medium; and its amount may be increased by decomposition or oxidation occurring in the exudation. Hydrocele fluid has yielded 48 volumes per cent. of carbonic acid, 24 per cent. being free, and 24 fixed; pleuritic effusion 44 volumes per cent. of carbonic acid, 15 per cent. being free, and 29 fixed; peritoneal fluid 10 volumes per cent., 7 per cent. being free, and 3 fixed; œdematous fluid of the extremities 24 volumes per cent., 17 per cent. being free, and 7 fixed. In many of the liquids to which I have referred above, the tension of the gas is greater than it is in the blood. Only traces of oxygen and nitrogen, it may be added, are to be met with in any of these exudations.

Dr. McVail (Glasgow) congratulated Professor Charles on the very careful and important experimental research, the results of which he had brought under the notice of the meeting. If the processes of estimating the gases in the secretions and excretions could be so simplified and systematised as to be possible of application in ordinary clinical work, an important service would be rendered to medicine. Up to the present, while physicians had made great advances in practical acquaintance with the greater mechanical actions of the body, such as respiration and the circulation, they could do little in the way of estimating the metabolic changes going on in the cells of the organs and tissues, although abnormal conditions there might be said to constitute the very fountain-head of disease. More particularly were Dr. Charles' remarks on the gases of the bile of great importance, and investigations pursued in the same direction could not fail to extend greatly the knowledge of the metabolic processes going on in the liver. He trusted Dr. Charles would continue the important work on which he had so successfully entered.

Dr. Anderson (Galway) said that it was of the highest importance that the gases as well as solid constituents of a tissue or fluid should be exam-

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ined. The fresh bile from the receptacle was undoubtedly a fluid good for analysis, and it must always be recollected that such a fluid had been taken from the gall-bladder. The bile might, and indeed must, undergo changes in its course from the capillaries to the gall-bladder. In passing along the intestinal tube, it was altered; whilst it remained in the gall-bladder, it became changed. The greater part of the oxygen of the blood was undoubtedly consumed in the tissues; but the blood in a tissue was itself undergoing change at all parts of its course. Oxygen must be consumed, and carbonic acid produced in the lungs, as well as in the liver or skin. Urine in the capillaries of the kidney was not the urine of bladder; the saliva of the acini was not the saliva of the duct; and the bile of the gall-bladder was not the bile of the hepatic capillary ducts. Chemistry alone could teach the accurate constitution of tissues, and to that science we must look for progress.

Dr. Charles said, in reference to Dr. McVail's remarks, that he was afraid the method of estimating the gases in liquids pursued at present was of too complicated a nature to be made use of in clinical investigations. As to the statement that the results of the analysis of the gases of secretions were not reliable, owing to decomposition occurring in the secretions after death, he held that this objection would not apply to his experiments, as they had all been made on bile flowing directly from the liver. Indeed, results of this kind were, in his opinion, as trustworthy as those derived from an investigation of the gases of the blood.—*J. J. Charles, in Brit. Med. Jour.*

Hysterical Drop-Wrist.—On reading the cases of hysterical paraplegia reported by Dr. Suckling and Mr. Mason Pooley, in the *Journal* for January 31st, it occurred to me that a case I treated two years ago may be one of some interest.

I had an urgent call to see E. D., a girl, aged 16, who had suddenly lost the use of the extensor muscles of the wrist. There was no history nor appearance of lead poisoning, nor injury to the trunk of the musculo-nerve; but about a year previously I had treated a ganglion at the back of the wrist by seton. Some good-natured friend had prophesied that she would have paralysis of the hand, and she had brooded over it until she again came under my care. Sensation over the whole arm and forearm varied much in a few minutes, at one trial a portion of skin appearing anesthetic, and very shortly hyperesthetic. It will be observed that, as in Dr. Suckling's case, there was a "traumatic history." The treatment consisted in impressing on her mind that she would recover, a free use of mistura aperiens alba, and stimulating liniments freely applied. She was well in a week.—*Vere G. Webb, in Brit. Med. Jour.*

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Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

Antipyrine; Prompt and Reliable Antipyretic.—Numerous reports have a few months since been published in various periodicals, upon antipyrine, a product of chinoline, to which Knorr, of Munich, gave the lengthy and rather anti-euphonic name (for us) of "dimetyloxycchinizine." To this choice of name there is probably more than we can deprehend at a glance; it strikes me, after mature thought, as a splendid means of cure for stammering physicians and druggists, though rather detrimental to their anti-profane proclivities. Filehne, of Erlangen, who has studied antipyrine on a therapeutic standpoint, has pronounced it an excellent antipyretic, and this has been corroborated by Huchard (*Union Medical*), Sayers (*Annales de la Societe Medico-Chirurgicale de Liege*), Ernst (*de Zurich*), Rapin and Secretant, in Switzerland, Guttmann, Falkenheim, See, and other eminent investigators.

The experiments have so far been altogether clinic, with the exception of a few conducted by A. Henocque, aided by M. Arderin, which have demonstrated that in large doses it provokes paralysis (paraplegia) and convulsions akin to strychnism, causing death by asphyxia. The therapeutical dose of antipyrine is from 4 to 6 gram. (℥i to ℥iss), which acts slowly, progressively and persistently, as an antipyretic, reducing, in the lapse of a few hours, the temperature from two to three degrees, Centigrade. This reduction lasts one or two hours; then the thermometer gradually ascends, to register its maximum at the end of about from six to twelve hours. These characteristic effects are constant chiefly in phthisis, when the daily dose of 2 or 3 gram. (℥ss to gr. xlv) is sufficient to obtain them. The same accord among the experimenters is not met with as it regards the concomitant phenomena, with the exception of the production of profuse sweats, and the elimination of the drug by the renal excretions. With regard to the frequence of the pulse, the results are contradictory. No changes, as yet, have been observed in the blood, in the exhalation of carbonic acid, and in the texture of the tissues under antipyrine, in therapeutic doses. This substance acts also as an hæmostatic, and is more powerful than ergotine and perchloride of iron (Henocque).

Antipyrine has been administered hypodermically, with the object of preventing the vomit, which occasionally occurs after its ingestion. The following are the conclusions in this regard, by Rank:

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1. In pyretic affections, and especially in pneumonia, pleuritis, typhoid fever, acute rheumatism and tuberculosis, it is an anti-pyretic, reliable and prompt.

2. Hypodermically, it reduces the temperature lower and quicker than when ingested.

3. The hypodermic dose should be smaller and less frequent than by the stomach. Two gram. (38) is sufficient in the former case, whilst in the latter, many a time, a dose of from 4 to 6 gram. is required.

4. The best adaptable solution for hypodermic use is prepared with hot water in the proportion of 2 per cent, which does not precipitate by cooling.

5. The injections provoke no alteration, either local or general.

6. The hypodermic method should be preferred, except in the practice of children and weak subjects, when a rapid lowering of temperature is rather hazardous, because it avoids vomiting and requires a smaller dose.

7. Anti-pyrine is called to fill a great gap in our future therapeutics.

Pain and abscesses are reported to occur sometimes at the point of the insertion of the needle. (Dr. Alexander.)

The sweats which frequently appear during the period of lowering of the temperature, have been successfully checked by the use of agaricine or atropine in 5-milleg. doses, taken 15 minutes previous to the administration of antipyrine, without interfering with its antipyretic action Riegel de Giessen and Guttman have employed it with success in fifty-nine cases.

Antipyrine is an excellent antipyretic; it lowers the temperature in a rapid and sustained manner, in some febrile affections. Its effect is nul in periodic fevers.—*Gaceta Med. Catalana*, Barcellona, Feb. 28, 1885.

Satyriasis and Priapism.—A remarkable case in all its features it has been our lot to observe in the *Hospital Clinico*, of Toledo. The subject was a young man from Madrid, who, at the tender age of 8 years, was initiated in the pleasures of Venus. In one so precociously enlisted under the colors of the goddess, it is not surprising that his youth has been expended in a series of uninterrupted excesses in coition and onanism, yielding with insane instinct to the most repulsive practices in the chasm of prostitution. As mementoes of his numerous battles, he carries, if not honorable, at least indelible cicatrices. Under appropriate medication for the lapse of six months, and with solicitous maternal nursing, away from evil influences, his syphilitic descrasia was ameliorated and his strength restored, when he began to have frequent and prolonged erections, preceded by voluptuous dreams, and followed by pollutions. At the age of

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19, he reiterated his visits to the domicile of vice, and then experienced an extra amount of venereal orgasmus, to the extent of enabling him to accomplish coition twenty-four times in the space of one single night, without other inconvenience than a feeling of intense fatigue and a constrictive pain in the epigastric region, which lasted from three to four hours.

Emaciation and waste advanced at long strides, and yet he could not overcome the excess of his passions, though conscious of the peril. Thinking that the country air might benefit him, he left the city and took his quarters at a country place near Toledo with an aunt of his, who, by her old age and maladies, ought to be considered an antidote for his suffering. The first few days in the country appeared to have somewhat modified his genetic instincts; suddenly, one morning, while quietly at breakfast with his aunt, he is taken with a vertigo, accompanied by a strong erection; thus siezed by satanic lewdness, he assails the old lady, who succeeds in escaping his satyric attack through the intervention of the neighbors, attracted by her loud clamors. Enclosed in a room, he repeatedly indulged in masturbation, subsequently entering into a period of calm, interrupted by furious crisis at the presence of any woman, irrespective of age or condition. Even the presence of his mother was sufficient to startle these satyric paroxysms, revealed by obscene and bold phrases, indecent gestures and highly reprehensible actions.

For the space of six months he was incarcerated in a dark room, deprived of light and bound to the bed, conscious however of his miserable condition. Then some improvement occurred, which has gradually increased, chiefly since his admission into the hospital, but even now the presence of his sisters or any other women, young or old, is sufficient cause to arouse his disordered appetites. Horrible physiological mystery! He is conscious of the moral turpitude of his acts, and yet he is impotent to overcome them. In the depth of his conscience there is a constant struggle between the sensual instincts and the attributes of virtue, wherein the carnal desires carry the laurels of the conquerer. The therapeutic agents which have best succeeded in this case are tranquillity, silence, refraining from the presence of women, opiates, bromide of potassium, camphor and cold douches.—*El Dictamen, Madrid, 10 de Marzo, de 1885. Polo Giraldo.*

Antiseptic Intestinal Medication.—Stercoræmia.—Dr. Dujardin-Beaumetz, in a recent conference at the Cochin Hospital, has established upon a scientific basis beyond doubt that the intestinal contents contain in the physiological status:

1. Micro-organisms discovered by Leubbenhock in the fæces, and sub-

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sequently studied to the point of describing a great variety of species. These micro-organisms are derived both from the ingesta and from the atmosphere.

2. Organic alkaloids and all the derivatives from the putrefaction of the albuminoids. These alkaloids, once in the blood, are prone to act as cardiac poisons, thus provoking convulsive alterations and modification of the pupil. There are several circumstances which can hinder their elimination through the natural channels of the organism, giving rise to certain phenomena, akin to those of uræmia, called stercoræmia. The kidneys and the intestine eliminate the toxic alkaloids, and the liver destroys them in part. If, however, this equilibrium is disturbed; if the renal glomeruli are obliterated; if a too rapid absorption occurs in the intestine, through loss of epithelium or ulceration, or because the phenomena of putrefaction are not sufficiently attenuated by the digestive ferments; or finally, if the liver fails to act, then the pathologic condition, called stercoræmia, is manifested.

Purgatives are the agents employed to favor the elimination of toxic substances out of the intestinal tract. Belloc's charcoal, in rectal injection, in the dose of two or three tablespoonfuls, suspended in six ounces of water, is a good means to modify the intestinal contents, but as this action is not thorough, in order to reach the whole of the intestinal tract, the use of the antiseptics by the stomach is required. Among these M. Dujardin-Beaumetz gives the precedence to Belloc's charcoal, iodoform and bisulphide of carbon. This is his formula: bisulphide of carbon, ʒ j; water, ʒxiij; essence of peppermint, 30 drops. M. Put the mixture into a quart bottle, shake, let it rest, and take 8 or 10 tablespoonfuls daily in a teacupful of milk. The same mixture is used to disinfect the bed-pans or closets to destroy the germs of infection.

Dr. Dujardin has for the last six months employed this sensible and economic mixture in typhoid fever, in the dose of six tablespoonfuls daily, with excellent results, as an intestinal antiseptic, without any accident.—*El Dictamen*, Madrid, March 10, 1885.

Foreign Students in the Faculty of Medicine of Paris.—From the report of the Dean of the Faculty of Medicine of Paris, read before the Academical Council, at the last session, the following is abstracted: In 1883-4 the number of our students is about the same as the previous year. On October 15, 1883, we counted 3,933 students in actual attendance. In the practical course in 1883-4, 557 matriculants were added, which gives a total of 4,490 students registered in our books, for the year 1883-4. Deducting from this number 496, including those who passed

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their examinations for the degree of Doctors in Medicine, and health officers and also those who died, etc., it remains 3,994 students representing the aggregate of our attendance on October 15, 1884, or at the commencement of our lecture year. The number of foreign students or doctors who enter the Faculty of Medicine of Paris, either to obtain a total or partial scholarship or to be examined for the degree of Doctors of Medicine, increases every year. In 1882-3, we had 108 new matriculants; in 1883-4, this number raised to 113; next year, it will, probably, increase still more. The total number of foreign students of the male sex registered in our books, Dec. 1, 1884, is 538, composed as follows: Americans, 127; Russians, 96; Roumanians, 61; Spaniards, 52; Turks, 45; Brazilians, 30; Swiss, 26; Greeks, 25; English, 22; Servians, 12; Italians, 9; Egyptians, 8; Belgians, 7; Hindoos, 5; Hollanders, 3; Portuguese, 3; Northern Germans, 2; Austrians, 2; Finlander, 1; Chinese, 1; Persian, 1. Total: 538. The number of female students registered in our books October 15, 1883, is 45. The present year, 1883-4, their number reaches 78, distributed as follows: Russians, 47; French, 13; English, 11; American, 3; Roumanian, 1; Hungarian, 1; Hindoo, 1; Turk, 1. Total, 78. C. C P. S.

Laryngology.

Edited by GEO. F. HAWLEY, M.D., 125 State St.

Treatment of Infectious Sore Throat.—I always administer an emitic in the beginning. As long as vomiting lasts and the tongue appears coated, I give as little nourishment as possible. All my patients were young and vigorous, so that, instead of stimulating, I had more than once the idea of bleeding, and would have done so, on account of the active inflammation, had not the feeling of general debility which attends these cases restrained me. This period usually continues to the third day, when, the irritability of the stomach having ceased, I let them take fluid but nutritious food, returning to solid aliment as soon as the condition of the pharynx permits its being swallowed without injury to the inflamed parts. I further advise the patient to use the following gargle every ten or fifteen minutes:

℞ Acid salicylic.....3 j
Acid Carbolic.....m xxiv
Sodii borat.....gr. lxx
Glycerine.....f℥ j
Aqua distillat.....f℥ xj M

Sig.—Use as a gargle.

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Internally I order a teaspoonful, in half a tumblerful of water, of this medicine:

℞ Quinine hydrochlorat.... .....gr. xxxvj
Tinct. ferri chlorid.....f ʒ j
Acid muriat. dilut.....f ʒ ij
Tinct. cardamom. comp .....
Glycerine.....
Syrup. aurant. cortic., *aa* q. s. ad.....f ʒ iij M

This is taken every three or four hours until the more moist appearance of the tongue and the general condition of the patient indicate amelioration of the symptoms, when the size and the frequency of the doses are rapidly diminished. As soon as the first indication of disturbance of the urinary function sets in, I prescribe a teaspoonful of infusum digitalis, to be taken every four hours. When the secretion has been re-established, I still continue for one week longer the same dose; for another day the patient is directed to take it but three times daily, and then this medicine is stopped, having achieved its purpose. If the pain in the neck or in the shoulder be very severe, I have found the best result from this liniment:

℞ Chloral hydrat ... .ʒ j
Camphoræ .....ʒ ss
Ol. amygdal.....f ʒ j M

Sig.—To be applied with a camel's hair brush to the painful parts, the application to be renewed on return of pain.

Besides paying attention to the bowels and employing general measures, as regular feeding, cooling drinks, sponging of the body several times daily, etc., the above contains the whole treatment. For the sleeplessness commonly met with in the beginning I have ceased to prescribe, as experience has taught me that the patients feel better, regain sooner their natural sleep, and recover more quickly, when no hypnotic whatever is employed.—*Hugo Engel, M.D., in Phil. Med. Times.*

Dermatology.

Edited by HENRY J. REYNOLDS, M.D., 2200 Michigan Ave.

Ringworm of the Scalp.—*A Clinical Lecture at the College of Physicians and Surgeons of Chicago. By Henry J. Reynolds, M.D., Professor of Dermatology.*—GENTLEMEN—I wish to-day to engage your attention while I speak of the condition known as *tinea trichophytina.* Under this head are embraced what are usually described as three separate and distinct affections, viz., *tinea circinata*, or the common ringworm of

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the face and body, *tinea tonsurans*, or ringworm scalp, and *tinea sycosis*, or ringworm of the beard, called also *tinea barbar*, barber's itch., etc.

They are all embraced under the head of parasitic diseases, and are produced by one of the three vegetable parasites, recognized as capable of producing skin diseases, viz., the *trichophyton tonsurans;* the other two forms of vegetable growth or parasite, as they are called, giving rise to the diseases known as *tinea favosa*, or favus, and *tinea versicolor*. These three forms of disease, then, while they differ in a measure, as regards their pathology and symptoms, are identical as regards their etiology, being produced by one and the same parasite; the difference in their manifestations being due entirely to the location.

I have here for your inspection a case of tinea tonsurans, or the disease as it is manifested in the scalp, and will to-day confine my remarks entirely to that form of the disease. Before examining the case, however, I think it advisable that you have a knowledge of the general characteristics of the disease. The parasite, on being deposited upon the skin, finds its way beneath the horny layer, and there commences its work. Soon a small reddish spot is seen. When first discovered, however, these spots are generally as large as a nickel five-cent piece, and covered with fine, somewhat adherent scales. They may be either multiple or single when first seen. They then increase in size and number, until soon several such patches are visible here and there over the scalp, varying in size from that of a dime to an inch or two in diameter. Something much more interesting as a diagnostic point, however, is generally apparent within the first few weeks of the existence of the disease, and usually when first seen by the physician; and what I now say has reference to the condition of the hairs. In our examination, the first thing we observe in this respect is a thinning of the hair, or partial baldness; but, upon still closer examination, we find that the hairs are broken off near the scalp, leaving stumps from one-eighth to a quarter of an inch in length. In a hasty, careless examination, these stumps of hairs may sometimes be overlooked, but by careful and close examination, I think, some of them may invariably be discovered when the patient is first seen by the physician. In addition to this the hairs will be found to be dry, lustreless and brittle, and may be removed from the patch by very slight traction, either breaking off near the skin, within it, or coming out entire, though I think hairs thus diseased are more likely to break upon traction. The subjective sensation is that of slight itching. More rarely we find a vesicular or pustular condition; the conditions, probably, most favoring this form of lesion being moisture and irritation. This disease, like all other parasitic diseases, is contagious.

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The history of the case is as follows: The patient is 8 years of age, and has had the disease six weeks. Another child, in the same house, has a similar trouble, from whom this patient, he states, caught the disease. You will observe, as he passes around among you, first, several patches, from one-half to an inch and a half in diameter. You will also notice that the patches are covered with dry scales; that there is a decided thinning of the hair on each patch, and by a little closer inspection you will see very distinctly short stumps of hairs here and there over the patch. The patches are somewhat circular in form, and the patient gives a history of slight itching.

Now, while there are several other diseases which have features in common with this, there is no other disease that gives the above combination of symptoms. Perhaps the principal or only diseases which we might be called upon to exclude, in making a diagnosis, are eczema, psoriasis, favus, and seborrhæa. In eczema we have greater itching, always moisture; it generally crops out on the face or ears as well, and we never get the characteristic thinning and stumps of hairs; we have more inflammation and infiltration, no history of contagion, and the patches are not so accurately defined.

Psoriasis may be excluded in this case by the absence of its characteristic white shiny scales, which on removal leave the almost pathognomonic red bleeding patch, and by the presence of the stumps of hairs which we do not have in psoriasis; and, moreover, psoriasis affects the whole body, the patches are smaller, and, when the scalp is affected, the disease almost invariably fringes the brow on the non-hairy forehead.

Seborrhæa is a symmetrical affection of the scalp and never occurs in accurately defined circumscribed patches, and further, the scales are greasy, there are no stumps of hairs, etc.

In favus, which is another parasitic affection, we have, as in this disease, stumps of hairs, but we have other points of difference. We have in favus *crusting*, a form of lesion that is not common in tinea tonsurans. Besides, these crusts have features that are almost pathognomonic of favus, and that we never meet with in tinea tonsurans, viz: They are *sulphur-colored* and *cup-shaped* or umbilicated. It will therefore be seen, that while from a hasty consideration of the gross features in a general way, an accurate diagnosis may seem difficult, by carefully considering the individual symptoms of each, a diagnosis may be made with absolute certainty. It is well to remember, however, that stumps of hairs, to say the least, are always suggestive of parasitic trouble. There is still, however, another diagnostic point, to which I have not yet called attention,

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and which will in any case, *per se*, clear up the question; that is, the discovery of the parasite with the microscope; to which subject I will again call your attention at the close of the lecture.

As regards the etiology, the disease is, of course, always the result of contagion, the propagating element being the parasite or vegetable growth known as the *trichophyton tonsurans.*

As to the pathology, it is essentially a disease of the hair and hair follicles, the invasion of the hair structure by the parasite being the cause of the brittle, dry, lustreless condition of the hair, and the same condition in the root causing atrophy of the bulb, etc. This brings us to the question of treatment.

The disease being of parasitic origin, and the deep structures—hair follicles, etc.—being involved, the treatment, in order to be effectual, must be such topical application as will be capable of destroying the parasite, and must likewise be used in such a form or way as to penetrate to the bottom of the follicles. Any of the ordinary parasiticide remedies may be used, and are capable of curing the disease, provided the remedy come in contact with the parasite. But this is not always so easy of accomplishment, and to facilitate matters, epilation, or the removal of the hairs, has been practiced, with a view to allowing the remedy to penetrate to the bottom of the follicles, and with apparent advantage in stubborn cases. Among the remedies used may be mentioned the various preparations of mercury, iodine, sulphur, chrysarobin, pyrogallic acid, chloroform, ether, etc. The mercury may be applied in the form of the bichloride, grs. x to aqua ʒi; iodine in the tincture. The hyposulphite, or the sulphite of sodium, a drachm to the ounce of water, will be found one of the best remedies. In any case, before applying the remedy, the surface should be thoroughly cleansed by the free use of green soap and hot water. In this case we will apply a solution of chrysarobin 15 grs. to the ounce of chloroform, which should be thoroughly and frequently applied. The chloroform has a tendency to dissolve sebaceous and other fatty or gummy matters away, and thereby facilitate the penetration of the remedy down into the follicles. If this proportion seem to create irritation, the strength must be diminished. Care should always be taken to avoid contagion through the medium of combs, towels, brushes, etc.

We will now briefly refer to the discovery of the parasite with the microscope. I now take from the patient's head, as you see, one of these stumps of hairs and also from this gentleman's head a healthy hair, having the piece of sound or normal hair longer than the diseased one. The patient's hair, as you see, is much lighter in color than the normal hair

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which we take from the gentleman's head. We now moisten these with a little water on the glass slide and place them under a magnifying power of about four hundred diameters. The first thing you now notice, as you each examine this specimen, is that the patient's hair, which is normally lighter in color, is much darker under the microscope than the healthy one. The explanation of this is, that the diseased hair structure is so stuffed full of the spores of this vegetable fungus, that it renders it opaque, and hence darker in color than the sound hair. The next thing you may notice is a great number of small, round or globular bodies all along each side and at the end of the diseased hair; while the normal hair will be seen to be entirely free from these bodies. In other places near the diseased hair you will see, here and there, large clusters of these same bodies. Now this trichophyton tonsurans, or vegetable growth, or parasite, as it is called, is made up of what are termed spores, and mycelia or thread-like bodies; and the round bodies I now call your attention to are the spores; and in this way, by placing a sound and diseased hair close together on the same slide so that both come into the field at once to be examined and contrasted at the same time, the condition may be ascertained with positiveness by the most inexperienced observer.—*Jour. American Med. Association.*

On the New Remedies for Psoriasis.—During the last few years, some real progress has been made in the local treatment of skin diseases. Amongst the new remedies which have come into use, chrysophanic acid holds a conspicuous place. Its effect in curing psoriasis is undoubted; and if it be not universally employed, it is more on account of the inconveniences connected with its use than from any doubt of its real efficacy. Several ingenious methods have been lately introduced with the object of remedying these inconveniences. Amongst them, Pick has recommended a mixture of gelatine and chrysophanic acid in different proportions, and the method has now been introduced in the profession for some time.

Auspitz has lately conceived the idea of using "traumaticin" instead of gelatine as an excipient for chrysophanic acid, traumaticin being a solution of one part of gutta-percha in ten parts of chloroform. This preparation adheres closely to the skin, and remains from two to three days without change. Gelatine, on the contrary, becomes detached within several days by the rubbing of the clothes or the movement of the limbs. Traumaticin forms a much thinner and more delicate pellicle than either collodion or gelatine, and is more easily borne; and as applications made with the solution of the strength of ten per cent. have never provoked irritation, even when applied to considerable surfaces, either in children or adults—

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the chloroform evaporating slowly and the gutta-percha becoming only gradually hard—it is easy, whilst making an application, to rub it well in upon a considerable number of patches. By means of this rubbing the scales can be removed, and the chrysophanic acid directly applied to the bare and bleeding patches.

The method of Auspitz is carried out in this manner. After the scales have been removed by means of a bath and application of soap, all the patches are dabbed and rubbed with a brush steeped in a mixture of the strength of ten per cent. If the affection be not extensive, the application is renewed each day. If it occupy a large extent of surface, it is renewed only in two or three days. If the scales be in considerable quantity, a soap-bath is prescribed. If the scales be not very plentiful, soap-lotions are sufficient. After one or two rubbings many of the patches appear flat, and in general the scales persist only on the borders of the patches. After two, or at the most a dozen, applications, according to the intensity and extent of the psoriasis, the infiltration and scales disappear, and in their place are found white prtches surrounded with a red or violet-brown border. When the disease is limited in extent, one application renewed daily for three to six days is sufficient to cause the patches to disappear, without the necessity of having recourse to lotions or baths.

M. Besnier has experimented with all these methods in the St. Louis Hospital, Paris, and gives a preference to the method of Auspitz, which, however, he has somewhat modified. After removing the scales, he rubs the patches with a common housepainter's brush, soaked in the mixture of chloroform and chrysophanic acid at fifteen per cent. The duration and energy with which the application is made should vary according to the thickness of the patches of psoriasis. The application gives rises to a slight sensation of heat and smarting; in a few seconds the chloroform has evaporated and the patch is literally infiltrated with pure chrysophanic acid, having become of the deep yellow color of iodoform. It is only then that, with a large flat brush, the patch is covered with a layer of traumaticin, which must be thickly laid on, and which extends beyond the borders of the patch. The result is said to be excellent.

M. Besnier has applied this method even to parts covered with hair, and without any untoward accident, local or general. The method has been found useful chiefly in cases of moderate infiltration; but when the patch is thick, fissured, and desquamating abundantly, the effect is not so striking. In such cases he has used, instead of chrysophanic chloroform, a ten-per cent. solution of pyrogallic acid in ether, which is then immediately covered with a layer of traumaticin.

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In this connection we would, however, remind our readers that pyrogallic acid must be applied to the skin with great caution, several cases having been reported in which fatal results followed its absorption.—*Brit. Med. Jour., by the Editor.*

Psoriasis Passing into Verruca and then Epithelioma.—Dr. James C. White (*Amer. Jour. Med. Sci.*, January, 1885) gives two cases in which this extraordinary sequence of pathological process was observed. The first was that of a gentleman, æt. 27, who presented himself in 1866, suffering from a well-marked psoriasis scattered over the general surface, of six years' standing. He remained under treatment ten years, during which time all known remedies were employed without success. The eruption, which was always intolerant of local remedies, came and went, but never wholly disappeared from certain localities, as the scalp and backs of the hands.

Ten years ago several patches in the latter parts, and lower forearms especially, began to undergo a change, their bases becoming less hyperæmic and they themselves more elevated and less scaly, until they were gradually converted into sharply-defined, prominent, firm, and horny outgrowths, some of them resembling the unpigmented formations of keratosis senilis in the same localities, while others were more like callosities or some form of warts.

Three years ago a patch on the right palm became excoriated and fissured, and in spite of treatment terminated in a small ulcer. Later a similar one formed on the left palm. Repeated cauterization and scraping seemed to heal these ulcers for the time, but repeated relapses occurred, and both palms finally became much more largely involved. The axillary glands were at no time involved. The patient's health now began to fail under the pain and anxiety, and amputation was suggested. He then, by advice of Dr. White, consulted Hutchinson and Paget in London, and Kaposi and Billroth in Vienna. The opinions of these gentlemen are not given. Finally, in April, 1884, the right hand was amputated above the wrist, and the fore and middle-fingers of the left hand were excised through the middle of the metacarpal bones. The patient recovered from the operation and regained his former health and spirits. There was no return of the disease in other parts. Microscopic examination of the parts removed showed the characteristic appearances of flat-cell, epidermoid cancer.

Dr. White's second case bears in many respects a close resemblance to the first, save that no intermediate verrucous growth could be ascertained. He quotes a third case frem Ziemssen's *Handbuch* (Bd. xiv., Hautkrank-

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heiten), in which psoriatic patches were found to eventuate in epithelioma.

The lesson to be drawn from the study of these cases is that the transformation of patches of psoriasis into verrucous hypertrophy must be regarded as an ominous occurrence, and that the softening or other change of such horny growths demands thorough excision without delay.—*Phila. Med. Times.*

Application of Remedies in Collodion to the Skin.—Barnes (*Amer. Jour. Pharmacy*) finds that wood-tar dissolves in collodion in the proportion of 1 to 4. An alcoholic extract of coal-tar reduced to a syrupy consistence dissolves in the same proportion. Half a drachm of iodine is taken up by an ounce of this solution. For oil of cade the proportion is 1 to 5; for gurjun oil, 1 to 3–4; balsam Peru and oleic acid, 1 to 4; glacial acetic acid and crystallized carbolic acid, 1 to 4; creasote and essential oil of mustard, 1 to 7; extract of belladonna, 1 to 8. Aconitine, atropine, and hyoscyamine dissolve easily; veratrine, by the addition of a little oleic acid, and morphine the same, as by the following formulæ: ℞ Veratrinæ, gr. vii.; collodii, ʒvii; acidi oleici, ʒi, M., or ℞ morphinæ, gr. iv ad ix; collodii flexile, ʒvii; acidj oleici, ʒi. M. White precipitate, iodide of lead, iodide of cadmium, and sulphur dissolve (?) in the proportion of 1 to 7; oleate of mercury and oleate of zinc, 1 to 4. Iodide of sulphur cannot be employed in this combination, as it becomes decomposed.—*Phila. Med. Times.*

Surgery.

Edited by G. FRANK LYDSTON, M.D., 125 State St.

Report of a Case of Ligature of the Right Primitive Iliac Artery for Diffuse Aneurysm of the External Iliac; Death from Pyæmia on the Twenty-first Day.*—M. McM., 22 years of age, a laborer, was admitted to Bellevue Hospital on the 8th of October, 1871, suffering from a painful, hard, but elastic pulsating tumor of the right inguinal and iliac regions, extending six inches above and two inches and a half below Poupart's ligament, and two inches and a half to the left of the median line, clearly marked in outline and evidentiy intra-abdominal.

The history of his case, given by the patient, was as follows: About two years before his admission to the hospital a barrel of lime had rolled against him, inflicting a contusion in the neighborhood of the right inguinal region. Soon after this injury he contracted urethritis, and also a

* Read before the New York State Medical Association, November 20, 1884.

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chancre, followed by an enlarged inguinal gland which soon subsided without suppuration. No constitutional symptoms ensued so far as he knew, and none were apparent when he applied for treatment on the 8th of October, 1871. Nine months before his entry into the hospital he noticed a tumor in the right inguinal region above Poupart's ligament. In three months after it was first noticed the tumor had attained the size of a hen's egg, and he then observed for the first time that it pulsated. In another period of three months it had very greatly increased in size, and, two months before his admission to the hospital, it had nearly attained its dimension noted on the 8th of October, 1871. The man continued his work of handling and sometimes even lifting barrels of lime, until the tumor had become very painful; not till then did he apply for treatment at the hospital. The pain was seated partly in the region of the tumor—and there it was of a burning character—but mostly in the course of the anterior crural nerve, as far down as the knee, from compression by the tumor.

In the physical examination of the case various tests were employed, among them that of placing at the summit of the tumor a square bit of white paper with one of its corners turned up. By this simple and well-known expedient the pulsations were rendered very distinct from a considerable distance (an excellent device for demonstration in a large amphitheatre). By palpation and compression the heaving of the whole tumor and its pulsation were made still more certain, while auscultation revealed the existence of a well-marked bellows murmur. The integument overlying the tumor was dark-colored and œdematous. The discoloration was believed to be due to rupture of the aneurysmal sac, the foregoing facts having led me to the diagnosis of traumatic aneurysm, and now of diffuse traumatic aneurysm, of the external iliac artery. There was slight pulsation of the anterior tibial, but none of the posterior tibial or femoral arteries. The patient was somewhat emaciated, but had no apparent lesion of the thoracic or abdominal viscera. On the 12th of October it was noticed, even by the patient, that the tumor had markedly increased since the 8th of October, and he said also that his pain was much worse, although he had taken a free dose of morphine. Besides, the local heat was greater than it had been for the three days past, and the rapid downward progress of the patient compelled immediate surgical interference. At a consultation with my colleagues, I proposed, as the only chance for the patient's life, ligature of the primitive iliac artery (and, if necessary, of the common femoral), to be immediately followed by free incision of the aneurysmal sac, in order that the blood clots might be removed and the whole cavity of the aneurysm cleansed. The gentlemen all agreed

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with me as to the necessity of ligature of the primitive iliac, but would not consent to any form of disturbance of the aneurysmal sac, and I yielded to their objection without, however, changing my opinion in relation to the propriety of incision of the sac, so warmly advocated by one of the best and wisest authorities of the early part of this century, and so successfully executed by Prof. Syme in our own time.

Operation.—On the same day, October 12, 1871, ether was administered to the patient in the usual way. The size and configuration of the tumor rendered the operation more than ordinarily difficult, and, for greater safety, it was thought necessary to adapt the course of the incision to the requirements of both. Before, however, I proceeded to cut, a trusty assistant was notified to be in readiness to compress the abdominal aorta manually in case the sac should suddenly burst when exposed. This provision made, I began my incision at the lower border of the tenth rib, in a line drawn from the center of the axilla to a point on the level of the anterior-superior spinous process of the ilium, and one inch nearer to the median line of the body than this bony process. This was the general course of the slightly curvilinear incision, which was nine inches in length, except the lower two inches, which formed an arc of a much smaller circle and took an upward and inward direction in the discolored portion of the integument. The object of this deviation in the line of incision was to permit greater retraction of the skin and underlying tissues, and thus afford more space to expose and reach the main artery. A few superficial bleeding vessels were secured, then the incision was extended through the oblique and transversalis muscles, and also through the fascia transversalis, bringing into view the subperitoneal connective tissue. After separating, with the fingers, the peritoneum from the transversalis fascia, retraction of the wound and protection of the tumor and peritoneal contents were effected, partly by one hand of an assistant, partly by means of a steel spatula about three inches broad (the same spatula that had been used for a similar purpose by the late Dr. Valentine Mott, and skillfully employed on this occasion by his son, Dr. A. B. Mott). By this large wound and very efficient retraction the artery was brought into view for one inch of its length. Nevertheless, it was somewhat difficult to pass underneath this vessel, from within outward, the Mott artery-needle, which was armed with a stout silk ligature, but the step was successful. Before knotting the silk, I made a careful examination, to be sure that the ureter or the iliac vein was not included in the embrace of the ligature, which was then securely tied. From that moment the pulsation of the tumor ceased. The wound was then cleansed, its edges were stitched, and the dressing was completed by the application of

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strips of adhesive plaster, layers of cotton, and a retentive bandage. The whole limb was swathed in cotton, and bottles of hot water were placed on either side. The operation was concluded in the space of thirty-two minutes. A hypodermic injection of ten minims of morphine solution was administered before the patient had recovered from his state of anæsthesia, and, when he did recover his senses, stimulants were given him in small and often-repeated doses.

On the 13th of October, in the morning, the pulse was 128 and full. A dose of aconite was given. In the afternoon the tumor had already softened and the crural neuralgia had vanished. The temperature of the affected limb was greater than that of the sound side.

On the 14th the pulse was 130 and full. There was little, if any, pain. He slept well, but had no inclination to eat. The tumor was softer and decreasing in size. The discoloration of the skin at the seat of operation had lessened. From the first day evacuating catheterism of the urinary bladder had been necessary, but on the third day he urinated spontaneously.

He had, during the night of October 14th, a sudden attack of diarrhœa, which was, however, quickly checked by a dose of morphine.

Early on the morning of the 15th his pulse was 130, and he was sweating profusely. Eight hours later he was much better; pulse 108, body temperature 102 degrees. In the course of another hour the pulse rose to 120, and the bowels became tympanitic, though he was generally better and in good spirits, eating well and with relish. There was some discharge of pus from the lower end of the wound, but none from the upper half, which appeared to be healing. The parts were washed and covered with sheet-lint soaked in carbolized glycerine and water.

On the 16th of October the pulse was 112 and the temperature 102.75 degrees. He had slept well all night, had no pain, and urinated normally. The adhesive strips were for the first time changed and some of the sutures removed, the upper half of the wound having healed. The lower half of the wound was unhealed, and there issued from it some sanious pus. The superficial dressing previously used was renewed. In the evening it again became necessary to use the catheter. The pulse was 112 and the temperature 101.25 degrees. On the day following the pulse was 100 and the temperature 101 degrees. The aneurysmal tumor began to show signs of rupture; its wall, at the lower portion and external border, had become extremely thin and black, and the overlying integument, for a space of two inches by four, was black and gangrenous. During the evening there was some febrile reaction. On the 18th of October the pulse was 102 and the temperature 101 degrees. The

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lower three inches of the wound gaped widely, but the aneurysmal sac had not yet burst. The catheter was used until the 21st of October, when the patient again urinated spontaneously. On the 22d dark tarry blood first began to ooze from the sac through a small opening, and the sac was floating, as it were, in a pool of pus. The gangrenous integument, being loose, was removed by slight traction. The patient began to complain of his chest, or rather of his lungs; but nothing is stated in the notes of the case as to the precise nature of the pulmonary complaint. This respiratory uneasiness may have been due to the existence of purulent foci in the lungs, since other signs of pyæmia had already manifested themselves.

Although the patient slept well and spoke of feeling well, he appeared to be daily losing ground, and his pulse and temperature obstinately remained abnormal.

On the 24th of October the pulse was 100 and the temperature 99.5 degrees. The area of ulceration over the tumor measured five by six inches, extending two inches below the lower extremity of the incision, and the sac began to protrude. On the 26th the pulse was 120 and the temperature 102 degrees. He had been sleeping well, but had no appetite. I cut short the slow spontaneous enucleating process of the aneurysmal sac by introducing a finger and sweeping it around that part of the sac which was out of sight, and at the same time removed portions of sloughy muscular tissue. No hemorrhage followed this procedure. After the sac had come away, I could, with the finger still in the cavity, distinctly feel the bladder. The tumor consisted of two sacs—the real aneurysm, which was of the size of a hen's egg, and an outer and larger sac, separated from the inner by a layer of firmly coagulated blood two inches in thickness. The cavity thus exposed was then thoroughly cleansed, and filled with picked lint saturated with carbolized oil. The removal of this foreign body seemed to give him great ease. In the evening, however, there was febrile reaction.

The diet of late had been one quart of milk and three eggs daily, and eight ounces of whisky. The internal medication consisted of quinine and aconite.

On the 27th of October he had a chill, which lasted fifteen minutes. He was placed upon a water-bed on account of the appearance of a bed-sore. The pulse was 140 and weak, and the temperature 103 degrees. The daily allowance of quinine was then increased to thirty grains. At two o'clock in the afternoon the pulse was 120 and the temperature 102 degrees, and at six o'clock he had a second, but severer, chill. On the 28th he had two chills, and his pulse was 128.

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On the 29th of October the pulse was 124. At 10 A. M. he had a chill, and began to sink. In the evening he complained for two hours of intense pain in the heel and foot of the affected side, though ordinary sensation was abolished, and the surface was cold. Warm applications to the feet were ordered, and a dose of morphine was given. On the 30th the pulse was 124. The pain in the foot was more severe, but was afterward relieved by opium. Chill at 9 A. M. The face was cadaverous; he was fast sinking.

On the 31st of October the right ankle was ecchymosed, but not swollen. The pain in the ankle had extended to the leg, and was intense. On that day he had several slight chills.

On November 1st the ecchymosis had greatly increased. The patient died on November 2d, at 2 P. M., at the expiration of the twenty-first day after the operation.

Autopsy.—The ligature lay loose in the wound and was removed. The primitive iliac artery was completely obliterated. Nearly the whole of the external iliac had sloughed away with the sac, leaving less than an inch of its lower extremity, which was entirely closed. There was a pelvic abscess which involved the psoas muscle. The femoral and iliac veins were pervious and free from thrombi. The wound had healed to the surface except in the track of the ligature.

The relatives of the deceased having objected to a complete autopsy, the examination was consequently confined to the pelvic region.

REMARKS.—The evil result of this case served to strengthen the opinion I had expressed as to the management of the sac after ligature of the artery, and reminded me of the more fortunate case of a soldier who, in 1861, received a sword-thrust in the upper part of the left arm and was brought to me a few hours after with a tumor, at the seat of injury, of the size of a hen's egg. I immediately expressed the belief that the brachial artery was wounded, and that the tumor, consisting of clotted blood, was the beginning of an aneurysm which, if left undisturbed, would eventually become diffuse. The injury being a little below the insertion of the pectoralis major muscle, pressure was applied to the subclavian artery, and I made a longitudinal incision directly through the tumor, turned out the clots, exposed the wounded artery, which I tied above and below the wound, then cut away the vessel between the two ligatures, and thus excised an embryonic aneurysm. It is fair to say that a wound of an artery is an aneurysm in embryo. The patient made a complete and rapid recovery. I believe that excision of a portion of a wounded artery is not a modern practice, but a revival, with but slight modifications, of what was long ago recommended and executed.

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The particular point in the report of the case of diffuse aneurysm to which I have the honor of asking your special consideration relates to the management of the sac. It seems to me that, in the case in question, if I had carried out my intention of freely opening the sac, the chances of recovery would have been greatly increased, and that this procedure, for which we have such strong warrant, and which is in itself so simple, so philosophical, and therefore so eminently surgical, should be more insisted upon than it has been of late years. The patient was in an excellent condition at the beginning to bear the proposed operation of incision of the sac. He succumbed from pyæmia solely because a great bag of dead and decomposing blood was retained in his flank. The necrotic process was so slow that it became necessary to resort to artificial enucleation of the sac, but the foreign body had already caused damage that could not be repaired. If after ligature of the main artery the sac had been freely opened and the clots extracted, and the cavity filled with lint, I am sure that the risk of this expedient would have been infinitely small as compared with the expectant plan which was so unfortunately adopted.

If I am wrong in this view of the case, I trust that those who think so will candidly tell me why. I therefore urge that the following question be fully discussed—i. e., Whether free incision of the sac of a diffuse traumatic aneurysm after ligature of the artery or arteries by which it is supplied is, as a general rule, a proper or an improper practice?—*John W. S. Gouley, M. D., in N. Y. Med. Jour.*

Extirpation of the Kidney.—Prof. von Bergmann, of Berlin (*Centralbl. für Chirurgie*, No. 45, 1884), says that this operation is no longer a rare one; for, since Simon's first case, it has been performed one hundred and twenty-one times. It may be indicated in a case of malignant tumor, or in one of pyelo-nephritis. In the former class of cases the operation is a very dangerous one, as it is necessary to perform laparotomy, and to make a double incision of the peritoneum. Moreover, a suppurating cavity may be formed behind the peritoneum, and discharge its contents into the abdominal cavity. Important mesenteric vessels are often divided, and thus a risk of gangrene of intestine is set up. Of twenty-four cases of operation of this kind, in seventeen death occurred during or soon after the operation, in five of which it was due to hemorrhage. Only four patients recovered. In cases of cancerous disease of the kidney, metastatic and disseminated growths are usually found at the time of operation in the intraperitoneal and mesenteric lymph-glands. Extirpation of the kidney has had much better results in cases of pyelo-nephritis, as of forty cases twenty have been cured. In one case, Von Bergmann attempted to attain a cure by simple incision of the numerous

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abscesses, but without success, as the suppuration persisted. The kidney was finally extirpated with a good result. In the course of twelve months he extirpated the kidney four times, in each case with success.

A RECENT writer in the *Canada Lancet* states that no cases of actinomycosis has been seen in England or America. Our county hospital "discoverer" should take notice.

Obstetrics and Gynecology.

Edited by E. P. MURDOCK, M.D., 179 South Sangamon St.

Impregnation with Hymen Unruptured.—Dr. Mosenmerer, of Cincinnati, reports a case of a young woman, æt 22, married two years, whom he attended in her confinement. Previous to her marriage she had been a patient of the doctor's, and had been treated for various ailments, but was generally as healthy as young women usually are. When summoned first the doctor gave opiates for irregular uterine contractions, which were controlled, and the woman was made comfortable for six days, when he was called again. She was then suffering with regular labor pains, and the waters were expelled at each contraction. A digital examination revealed a septum through which the advancing head could be felt beyond; but the finger could discover no orifice through the membrane except one no larger than the diameter of a small pencil.

Dr. Ratterman, called in consultation, confirmed the diagnosis as above, both by digital and ocular demonstration. A crucial incision was made, and the delivery of the head was readily effected by the use of small forceps. The husband asserted that coition had always been difficult and unsatisfactory.

The case is interesting in proving that impregnation can occur without actual entrance of the male organ into the vagina, establishes the possibility of pregnancy in attempted rape, and shows the vitality and activity of the spermatozoa in traversing this unusual distance.

Apropos to this Dr. Taylor gives two cases of retained menses owing to imperforate hymen; one a young woman apparently healthy, but with great abdominal distension, in all respects resembling the tumor of pregnancy.

The woman had never menstruated, but had regularly experienced the periodical malaise and discomfort natural to this function. The woman was taken home and an operation made to remedy the occlusion of the vagina. Recovery followed. The other was operated upon by Dr. Clendenin by puncturing the occluding membrane with a small sharp probe. In this connection the editor remembers a case which came under

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his operation during his pupilage, which passed through the hands of several physicians, and finally was operated upon by a well-known surgeon. A crucial incision was made and the great mass of retained menstrual debris was scooped out, and the vaginal and uterine cavities washed well. Antisepsis not having gained a footing at that time no germicide was used. The patient died the tenth day after the operation.

Vomiting in Pregnancy.—Dr. Galceran reports a case of very severe vomiting of pregnancy which had resisted every effort to control it, but which was arrested at once by the application of ether to the epigastrium. The vomiting began again at two different times, but was controlled immediately by a fresh application of the ether.

Dr. Waterman sends us reports of two cases that had resisted all ordinary treatment as well as exhausting the patience of the family physician, in which both yielded readily to mechanical dilatation of the external os uteri, and this without even threatening abortion.

On the contrary, Dr. Giles S. Mitchell contributes an able article upon this same subject, in which he shows that some cases resist all known treatment, and reports an interesting case with the treatment where in spite of the most skillful attention the woman died at the expiration of twelve days of "incessant vomiting." [*Obst. Gazette.*] Your editor has just passed through the ordeal of two unconquerable cases, in which spontaneous abortion finally relieved him of his responsibility and saved the patients in both cases. No credit is due him, however, for the present prosperous condition of his patients, since all his remedies were absolutely ineffectual.

New Operation for Incomplete Laceration of the Perineum.—Prof. W. Gill Wylie contributes a paper upon this subject, in which he takes issue with the leading authorities as to the chief functions of the perineum as well as the manner and direction of the tear, and in proof of his position he shows that we may have complete laceration of the perineum without prolapsus uteri or displacement of the rectum. In fact where the sphincter ani is destroyed the uterus is seldom displaced because the greatest force that acts to displace the pelvic organs is straining at stool, and not infrequently where there has long been persistent constipation this force stretches the ligaments, thins the perineal body, relaxes its resistence and produces rectocele and cystocele, even where we have no laceration. He explains the structures of the perineal body with its movable point for the insertion of the transversus perineal, the bulbo cavernosus, the sphincter ani, levator ani and some of the pelvic fascia, and thus showing that the external perineum may be torn and cause little or no trouble, but when the inner part of the perineum, where the rectum

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merges into the anus, then we have no resistence to the intra-abdominal force needed to expel the fecal matter which gradually forces down this thin unsupported partition, (the remains of a partially lacerated perineum).

The operation then contemplates as its main features, first, strengthening of the recto-vaginal partition above the vaginal orifice; and second, bringing into apposition the edges of the pub-coccygeus and pelvic fascia.

The operation then consists in denuding not the skin or tissues covering the labia, but the mucous membrane that once formed the osteum vaginæ as high as the old caruncles, laterally and gradually extending the denudation upward for an inch to an inch and a half in the vagina going laterally so as to include the depressed angles on either side of the rectocele in these angles, being careful to not injure the muscular structure of the vagina. The denuded surface instead of being crescent shaped or triangular or clover leaf, is nearly square, with its longer axis extending up the vagina. Now the sutures are put into the superficial perineum in the same as in the old operation, the third or fourth suture usually being inserted within the osteum vaginæ, dipping deep laterally completely under the denuded surface of the rectocele to its centre; then the needle is re-entered at the same place in the centre, carried completely under the depressed denuded angle and brought in the side of the vaginæ opposite its point of entrance.

After all the sutures are inserted, usually numbering six or eight, he then thoroughly stretches the sphincter ani; this relieves tension in that direction and lessens the risk of troublesome hemorrhoids and fissure.

No catheter is used except when the patient is unable to pass her urine. The bowels are made to move daily by mild laxatives, no bandage is used to the knees, and the patient is allowed any food she wishes.

The stitches are removed on the tenth day and the patient allowed to sit up four or five days later, but instructed to exercise the strictest caution for six weeks.

Regarding the perineum as a movable point of attachment for the transversus perinæi, the bulbo-cavernosus, the sphincter ani, levator ani, and some of the pelvic fascia, and also a movable point of attachment for the anus and lower end of the rectum, and lower end of the posterior wall of the vagina, the conclusions are:

First—As a rule when the perineum is completely severed so that the fecal matter escapes passively, the position of the uterus is not affected.

Second—The external portion of the perineum may be torn to a considerable extent and the position of the uterus will not be affected.

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Third—When the inner and upper part of the perineum is torn or overstretched and relaxed, prolapsus of the posterior and anterior walls will take place, and in time the uterus will be retroverted, prolapsed, and may be forced out of the pelvis.

Fourth—The explanation is that when that portion of the perineum formed by the fibers of the levator ani, and the pelvic fascia is torn apart, and the lower end of the vagina, and the upper part of the anus are loosened, so that they are not held up and elevated when extra-abdominal force is exerted, as in straining at stool, both are forced out through the vaginal outlet, and they pull and drag down the uterus, and in time result in hernea of the pelvic organs.

Fifth—In operating to restore the parts the aim should be to reunite the separated edges of the levator ani and pelvic fascia, and fix them *to* and in *front of* the lower end of the vagina and the anus, and the lower part of the rectum.—*Med. Record.*

Eye and Ear.

Edited by J. E. HARPER, M.D., 163 State St.

Movements of the Eyes in Brain Disorders in Children.—The eyes in infants and young children may be affected by various kinds of movements which usually indicate certain conditions or cerebral disturbance. The great sensitiveness of the nervous system in early life finds expression in some form of muscular spasm, but no part of the muscular system is more sensitive than that connected with the eye-balls, and their orbits. This is probably true of all periods of life, and is one of the chief reasons why the eye plays such an important part in expressing the mental process in action in the individual.

We propose to consider to-day those movements to which the term nystagmus is applied, and we must notice first that this term is too indefinite for clinical purposes, unless we describe its character with some additional term of exactness.

The eye may move in every direction, from side to side, vertically, or round its antero-posterior axis. We thus have lateral, vertical, and rotatory nystagmus, as three distinct kinds of movement. We may have only one, or we may have them all present in the same case. In the infant before us we perceive that not only the eye-balls are affected with vertical nystagmus, but also the head itself; and the movements of the head are chiefly of the same character as those of the eyes. The infant's age is between eight and nine months. She was brought here five weeks

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ago, and three weeks previously she had a convulsive attack, or rather she woke in the middle of the night with a scream, and then had a slight convulsion, which was followed by many hours of screaming. After this for about a week she was quiet, when, to use the mother's expression, she began "to work her head," and the eyes began to move. The mother has remarked the following peculiarity: that when she lets the infant lie back, and rest its head upon her knee, the eyes move much more actively than when the infant sits up, but the nodding movement of the head ceases. You may notice that this is true, and further that occasionally the head has a rotatory motion, a lateral nystagmus. There is no inclination of the head to the shoulders, and all movement appears to take place between the atlas and the occipital bone.

There has been no return of the convulsions since the first attack. The nystagmus of both head and eyes has varied in degree, on some days being much less than others. The infant is well nourished, and though she is at times restless and cries at night, she is usually as you see her now, in good spirits and inclined to notice everything around her. No particular cause is assigned for the convulsion. It is possible that it may have been connected with the cutting of the first lower incisor which preceded the attack by a few days. It is also possible that it may have been due to some inflammation of the internal ear, for the mother noticed that the child appeared to suffer with its left ear, as it was constantly raising the hand and rubbing that part as though in pain. It ought always to be remembered that this is by no means an unfrequent cause of convulsions in infants, as is often proved some few days later by a discharge from the ear. This, however, was not the case in the present instance. I think that I have explained to you the conditions of the mouth and throat, which apparently has a tendency to extend through the Eustachian tube to the inner ear, and is the cause of otitis.

It cannot be said that the child has improved much since we first saw it. It has been taking small doses of bromide of potassium and belladonna, and the general treatment has been such as is usual after an attack of convulsions, when the symptoms of a probable recurrence are present.

Now, before passing to the next case, one of lateral nystagmus and hydrocephalus, let me refer briefly to those authorities which you may consult with advantage on this subject. First there is an excellent treatise by Dr. A. Gadaud ("Etude sur le Nystagme," Paris, 1869), who quotes from a contribution by Odier, published in 1779 in the "Hist. Roy. Soc. Med.," and from an essay by Brachet, "Sur L'hydrocephaliteou Hydropisie," (1818), to prove that nystagmus is due to effusion into the cerebral ventricles. The chief result of Gadaud's personal observations was the

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distinction between symptomatic and idiopathic nystagmus. In the treatise by Boehm ("Der Nystag und dessen Heilung," Berlin, 1857), the view is supported that nystagmus is muscular like strabismus. Nakowz compared it to chorea; Von Carion attributed it to "refraction;" Kugel to retinal defects; and Javal to astigmatism. Each author is inclined to attribute too much to one cause. It is enough for us to admit the possibility of many causes, and our object is to study how to distinguish the one which is present in any particular case.

I must not omit to mention the observations of Dr. Ogleby on the "Nystagmus of Miners." (Transactions of the Ophthalmological Society, Vol. II.). In their case it appears that the movements of the eyes are vertical; that they occur when the head is held in a certain position; and that they frequently cease when the head is held erect. The inference which Dr. Ogleby draws is a reasonable one, that miners' nystagmus is due to the varying circulation in the diseased cells of the medulla; or, at least, that it is to be attributed to central congestion, and in no way to hypermetropia.

Now we will examine another case, one of well-marked hydrocephalus, with lateral nystagmus. The child is æt. 2½. She has been under our observation for fifteen months, and has improved much both mentally and physically, that is to say she has grown well and the head has not increased in size. She had an attack of convulsions when three weeks old, and the nystagmus began a few days after. There has been no fit since as severe as the first, but she has had frequent slight attacks of eclampsia, without loss of consciousness. In the intervals the nystagmus has sometimes entirely subsided, but after each attack it has been always more decidedly marked. The head is twenty-three inches in circumference and presents the common characters of not very advanced hydrocephalus. The eyes, as you see them now, are constantly moving left and right, that is they are affected with lateral nystagmus. The movement is regular, there is no twitching of the eyeballs, and in extent it is equal in both directions. We conclude from this that the nervous centres are equally affected in both hemispheres.

It often happens that the nystagmus is not a simple regular oscillation of the eyeballs as in this case, but the eyes move by a series of jerks to one side, and then it appears as if a partly conscious effort were made by the child to bring the eyes back to the direction in which it desires to look. For a second or more it can retain this position, till the muscular twitching again draws the eyes away. Clinically, therefore, we have a symptom of considerable interest in nystagmus, and when I said that we must define its character by some additional terms, it was with the object of

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determining the relation between the central disturbances and their effects on the eyeballs.

Nystagmus is not always present in hydrocephalus, and therefore we cannot suppose that it is caused by effusion. We really cannot say what the cause of it may be, but we can judge of the progress of a case by the variation of the nystagmus, for it will be found, I think, that when it continues after a fall, a fit, or some such accident for a length of time, that is for weeks or months, the prognosis is unfavorable.

Its association with squint is deserving of attention, for it suggests that they are due to similar central lesions. If the right eye has internal strabismus there are reasons for concluding that the left side of the brain is affected, and when the left eye is affected the lesion is probably in the right hemisphere. We may further remark that although strabismus and nystagmus are associated, there is probably more resemblance from a pathological point of view, between infantile paralysis and strabismus than between the latter and nystagmus, which may be compared with convulsions. This leads us to ask the question whether internal squint is due to paralysis of external muscles, or spasm of internal. It is an important question as I will explain on some future occasion. — *R. J. Lee, in Med. Press.*

Books.

THE STUDENTS' MANUAL OF VENEREAL DISEASES:—By F. R. Sturgis, M.D. New York: G. P. Putnam's Sons.

The fact that this little work has already reached its fifth edition, illustrates the demand upon the part of both practitioners and students, for small and condensed treatises upon the various specialties. The work in question is in substance, a series of clinical lectures delivered at N. Y. Charity Hospital in 1879 and '80 and to the greater portion of which we had the pleasure of listening. Whatever may be said of the substance of these lectures, no one can accuse Dr. Sturgis of verbosity or ambiguity in his teaching, for he is as clearly cut as possible, and his brevity in the class-room amounts to positive and very often irksome dryness. The classification embraced in the "Manual" is intelligible, although in some respects open to criticism. For example, we most decidedly object to the term, "simple venereal ulcer" as applied to chancroid. Chancroid is a specific affection—whether primarily or secondarily, does not concern us,—and in no sense simple. An ulceration due to simple irritation from gonorrhœal discharge, or from abrasion during intercourse followed by systematic neglect of cleanliness afterwards, would be simple venereal ulceration, but not chancroid, as Taylor would have us believe. We are glad to observe that the theory of the unity of gonorrhœal and chancroidal inflammation has not fastened its vicious grasp upon Sturgis. Accepting such

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unity, and accepting Kaposi's views of the unity of chancroid and syphilis, we would be reduced to abject poverty as to our supply of venereal diseases, and very much in the position of the Benedict who, when the minister pronounced his bride and himself "one," guilessly asked, "which one?" Not that we deny the possibility of the products of simple inflammation, when mixed with abnormal or normal secretions, undergoing a transformation under favorable circumstances of environment, and becoming noxious for we believe such to be really the case, but we do neny the unity of the mature and specific poison. Sturgis does not dwell with sufficient emphasis upon the fact that apparently innocent ulcers are often followed by syphilis and is too prone to ascribe great importance to "the period of incubation." Now there are just two things which we endeavor to impress upon the minds of the student, more assiduously than any others, viz: That a decided prognosis should never be given in any variety of sore, but the most typical cases of hard chancre, and that the history of the patient in 90 per cent. of cases is not worth a straw, and as a consequence the period of incubation so-called is never to be relied upon, excepting in cases in which a very long interval has elapsed since coitus, or when the patient has not been dodging about from one suspicious female to another. In speaking of multiple true chancre, the author denies the possibility of auto-inoculation. We are not so sure of this, for we have some evidences, which appear to show the primarily local character of syphilis, e.g., we once upon a time, excised a small chancre, which had attained its maximum of development, and had been stationary for at least a week. A free excision was made, with proper antiseptic precautions and an angular wound about one inch and a half long was left. This healed by first intention, but on the fourth day induration of the edges began, and finally developed an immense chancre, of a size and shape corresponding to the wound. We are certain that the whole neoplasm was removed, and if already constitutional, how did inoculation occur? Surely, such a case would bear out the view of the auto-inoculability of the initial lesion during the early period of its existence. We believe that Otis recognizes the possibility of such an occurrence for the first few days after the development of the primary sore. In speaking of the rapid cure of the initial lesion sometimes necessary in married people, mercury is evidently the main reliance, but aside from the fact that such cases as the one related above will sometimes occur, the knife or scissors with proper precautions, will prove the most effectual and rapid means of cure. We would like to see a more lucid explanation of the characters of the mucous patch than appears in Sturgis' treatise. It is sometimes less confusing to the student to understand that the plaques muqueuse are simply papules upon a mucous surface, and which depend merely upon their environment for their peculiar characters. There is a notable absence of anything like scientific pathology throughout the book. It will be found, however, taken all in all, quite a reliable elementary treatise upon the venereal affections. G. F. L.

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PHOTOGRAPHIC ILLUSTRATIONS OF SKIN DISEASES.—By Geo. Henry Fox, M.D., Clinical Professor on Diseases of the Skin, College of Physicians and Surgeons, New York. Second Edition. E. B. Treat, New York, Publisher.

It is perhaps almost unnecessary to call the attention of our readers to the fact that the second edition of this most valuable work is now ready for the profession. It is now only six years since the publication of the first edition, the translation of which, and its great sale, both in this country and abroad, together with the speedy demand for a second edition, must of itself be sufficient guarantee of the excellence and value of the work. The present edition, however, while it contains many of the illustrations of the old work, has been completely revised and much enlarged and improved, both as to the photographic illustrations and the text matter, and is now presented as a combined atlas and text-book. The illustrations are perhaps the most life-like of anything of the kind now in use, and take the work all in all, we consider it the most complete thing of the kind now published, and a work which should be in the hands of every skin specialist, general practitioner, and medical student.

H. J. R.

Miscellaneous.

The Fair Physiologist and the Bachelor of Medicine.

A Lay of the Nineteenth Century.

"Oh tell me, gentle maid," he cries, "whence flows that falling tear;
Why all suffused those glist'ning eyes? the cause I fain would hear."
"The cause," she says, with downcast eye, "unless my mem'ry fail, is
Intensified activity in the *Glandula Lachrymalis.*"

"But oh, methinks that from your breast there heaves a gentle sigh,
Refusing, too, to be repressed; sweet maiden tell me why?"
"I think," she says, "a sigh is due, to deepened *Inspiration*,
And this again is owing to some *Reflex excitation.*"

"But mantling on your cheek, I see the lovely damask rose;
Declare, oh dearest one to me whence this rich lustre flows?"
"Blushing is caused," the maid replies, "as Huxley well observes,
By much dilated arteries and *Vaso-motor nerves.*"

"But tell me farther, maiden dear, of all these signs the reason.
Do not a blush, a sigh, a tear, point to some *central lesion?*"
"Their cause" (she faintly makes reply) "as yet escapes detection,
Unless—perchance—they signify some—*cardiac affection.*"

"Ah, maid, your diagnosis true, to sure proof is subjected;
Since, by contagion caught from you, my heart, too, is infected.
And now to cure us both, I trow, one med'cine and no more is,
Oh, take the sweet prescription now: *Sume aurantii flores.*"

J. HARPER BENSON, in the *Century.*

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Medicine.

Edited by WM. E. QUINE, M.D., 3151 Wabash Ave.

Cerebral Pathology. — The *Lancet*, January 17, 1885, says: At the last meeting of the Clinical Society a paper was read by Dr. Hale White, on lesions of the frontal lobes. It is a matter of surprise, considering the freedom with which such questions have been discussed, that so much yet remains to be learnt. Has it not been accepted as a fact for some time past that injury to or disease of one of the frontal lobes is unattended with important damage of the ordinary functions of mental life? Whether this absence of symptoms is due to insufficiency of examination or not seems to be a matter worthy of consideration. Another possible view of the case is to suppose that in the recorded cases the individuals injured in the frontal regions have not been of the educated sort, and that as a consequence the functions which should have been present have never been developed. It seems certain that this kind of explanation would hold good for many cases of absence of symptoms when we have to deal with infants and others whose mental powers have not yet appeared, for the all-sufficient reason that the structures which entitle them to the possession of the faculties are then in an immature condition. Moreover, it would appear that Hartley's time-honored distinction between volitional and automatic actions is greatly in danger of being forgotten, or at least of being misunderstood. We should have thought that no one would have cavilled at Mr. V. Horsley's statement that the drawing of a triangular outline with one hand whilst the other was describing a circle was an impossible performance of consciousness. Consciousness is single and undivided, as best seen in close attention. But

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there are such processes as may safely be called sub-conscious, or almost unconscious, and amongst these must be classed the performances of telegraph clerks, weavers, and interpreters of music, whether of the Chopin order or not. It is not uninteresting to consider how far education would be possible in the absence of that most important principle which shows that volitional acts do, after a series of performances, become automatous, requiring very little or almost no guidance from the highest intellectual centres. The last meeting of the Clinical Society might not unreasonably be called a psychological evening, for both Dr. Hale White and Mr. Victor Horsley made the paper which the former read the occasion for some general remarks on the psychological functions of the cerebral cortex, if such a mode of expression, where mind and matter are confused together, be allowed. The latter gentleman is a supporter of the view that the highest intellectual functions are mostly energized from the hinder portion of the brain, whilst the frontal regions are the special seats of the highest emotional faculties, including, as we understood him, the power of giving expression to these. The lines of Hamlet, "See what a grace was seated on this brow; Hyperion's curls; the front of Jove himself!" would on this showing not be testimony to the intellectual faculties of the Queen of Denmark's first consort. However, the time has not yet arrived when we can speak with certainty on such matters, though it is clear from Prof. Ferrier's experiments and many clinical observations that the perceptive functions associated with the most intellectal organs of sense, the visual and auditory, are represented in the posterior regions of the cerebral hemispheres. The view which Dr. Hale White propounded with regard to the most recently acquired faculties as having no very definite site in the cerebral cortex, so that either frontal lobe may assume the functions of the other, would appear to have some kind of connection with the views of evolution and dissolution as propounded by Dr. Hughlings Jackson. Though it is usually taught that function precedes structure, yet there are many considerations which lend support to the notion that these elements go hand in hand. On this view it is not difficult to understand how, so to speak, virgin brain soil may be made by education to perform any functions whatsoever. True it is that through a long series of ages certain specializations have already been effected, and the development of the individual must on the laws of evolution proceed along the lines which heredity has laid down—that ontogenesis must be rapid phylogenesis. But, potent as are the influences of untold generations of experience, still the present agencies are in a measure, perhaps, more powerful.

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Erysipelas and the Antiseptic Method was recently made the subject of a lecture by Prof. Verneuil, in which he declared that "the antiseptic method, so powerful when used against contagion in general, is not so useful against erysipelas. At the same time it is certain that erysipelas is not so common as it was. In seeking the reason for this, let us first of all show that it is true that erysipelas is rare compared with what it was in former days. From 1862 to 1864, M. Gosselin had one hundred and thirty-three cases in his wards, and a mortality of thirty-one of these. Fifty were from outside and eighty-three arose in the hospital. From 1865 to 1867, M. Gosselin adopted a series of hygienic measures (such as better ventilation, separation of the patients attacked with the disease, refusal to admit cases from outside, etc.), so that in these three years he only had forty-five cases, with nine deaths. In 1872 I took charge of the service in Piete Hospital, after M. Gosselin, and found an epidemic of erysipelas raging, following the war of 1870-71. I made an effort to stop it by applying the doctrine of antisepsis to the fullest extent, employing all the Listerian methods. At the same time I allowed the cases from outside to enter, and did not keep up the separation of patients, with the following results: From 1877 to 1880, thirty cases and seven deaths,—six cases came from outside and twenty-four occurred in the hospital. In comparing these results with M. Gosselin's you will be struck with the difference, which I think that I owe to antiseptic treatment. Is it possible, therefore, to conclude that antisepsis is all-powerful? Evidently no. But if I could have separated my patients completely, no doubt it would have shown a better result. Here is the proof. I found in the three years mentioned no less than three small epidemics of erysipelas in the wards. The first was of five cases, the second and third took four cases, so that I should have had but twenty in all were it not for these outbreaks. Last year, from September to January we had not had a single case, when on the 12th of January we received a man with a wound in the head complicated with erysipelas. This was the signal for a new epidemic, which has not yet stopped, and counts me four already of the patients in my wards. Perhaps I would be still without any if I could have treated this case in a separate ward. Abroad, they apply the antiseptic method, but I see that erysipelas still exists. Some surgeons claim to have suppressed it altogether. I wish, then, they would tell us how it is to be done, and to what we shall attribute this persistence. The development of erysipelas in towns and without communication is without question."

Verneuil here relates two cases, one of a young woman who was attacked with erysipelas while she was living alone in a chateau in the

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country, away from all danger of contamination. The other case was similar; so that there are two ways of its spread in the hospitals, spontaneously and by contagion. He then laid down the following rules, first saying that erysipelas was a disease that no doubt had a parasitic origin.

1. Doctors in towns should, whenever possible, take care of these patients at home, and by proper measures endeavor to stop the spread of the infection.

2. If they are admitted into the hospital, they must be isolated.

3. If this is not possible, then at least they should be placed in beds as far as possible from the others, and a sort of *cordon sanitaire* established around them.

4. The treatment must attempt to destroy the germs of the malady, particularly by the prolonged carbolic spray, which has the double advantage of creating an aseptic atmosphere and acting topically at the same time.

5. Against interior erysipelas the precautions must be just as great. Employ antiseptic treatment along with emeto-cathartic and antipyretic agents, acid drinks, alcohol, aconite, etc.

6. The antiseptic precautions must be maintained after the disease has disappeared, as the danger of contagion probably continues during all the period of desquamation.

Dr. Le Fort, speaking on the same subject, said that for some time he had employed camphorated alcohol. He had done it at first so that the hospital assistants would not use the alcohol, but he finds that camphor in alcohol is an excellent antiseptic. He even prefers it to the ordinary carbolic-acid solutions for treating wounds. He thought that the antiseptic should not consist only in phenol, but hoped that some definite rules would be laid down, for what does well in one case does not answer in another. Alcohol alone he found did not answer so well.

Dr. Trélat did not think it mattered much, and said that it was best to take whatever was most convenient, whether, phenol, chloral, or corrosive sublimate. The main point was the use of antiseptics.—*Phil. Med. Times.*

Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

Disinfection by Chlorine and Bromine. —(Experiments made in the sanitary office of Berlin.) Virulent substances of all sorts, ferments, sarcinœ, etc., were exposed under a receiver, to the action of nascent *chlorine.* It was concluded, after many experiments, that in an atmos-

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phere saturated with humidity, the destruction of all microbia can be obtained by a determined proportion of chlorine, provided that the virulent objects are not enveloped, or disposed in thick coats. The proportion has been determined to average 3 per cent. in volume, when the experiment does not last over an hour, and 4 per cent. when it continues for twenty-four hours. In applying these principles to the practice of disinfection, great difficulties are met with. A special vaulted cellar was built, in which chlorine was generated over a series of objects which are habitually disinfected. The operation is not free from danger to the respiratory organs; fabrics and colors are rendered unfit for use, and the damages are relatively high. Moreover, the action of chlorine is imperfect and only affects the superficial micro-organisms. In resume, chlorine is a disinfectant, an unreliable and difficult one to handle. The same holds good in regard to bromine.

Orchitis versus Orthography—Inferring from the following note, the center which presides to orthographic correctness, lies in or about the testicles: *Mr. Drugest. Pleas give the boy 25 cts. worth of arica or something that will take out the soreness and swelling of a stone. I have caut cold and it setteld in one of my stones. If the boy has not money anough to pay you I will send him rite back with the balance.*

Resp. Yours, etc. *Chicago*, 4—9.

Remarkable Case.—A grocer, in our neighborhood, having his old delivery horse disabled both by age and sickness, applied to the nearest druggist for something wherewith to relieve the aged beast from the pangs of a death, which seemed impending. In token of gratitude for the services rendered him by the superannuated steed, the philanthropic grocer desired to promote an easy death. At the suggestion of the druggist, forty grains of sulphate of morphine were administered to the horse, in a single dose, and all the arrangements for a decent burial in the cemetery of a fertilizing establishment were made for the ensuing day. Next morning, ere preparing for the funereal cortege, the grocer, with tearful eye and sad heart, proceeded to the stable to view the remains once more; but, *mirabile visu*, the infirm horse, who for several days laid prostrated and helpless, stood before him eating at the manger, with an air gay and, to all appearances, happy. C. C. P. S.

Laryngology.

Edited by GEO. F. HAWLEY, M.D., 125 State St.

On Some Complications of Tracheotomy, with Illustrative Cases.—Among the cases which present themselves in practice of urgent dyspnœa

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in children, there are some in which a diagnosis is all but impossible; the urgency is so great, the history of its onset so vague and uncertain, that tracheotomy must be performed at once and the diagnosis established afterwards. Amongst such cases will be found a not inconsiderable proportion in which the dyspnœa is not due to diphtheria, but either to a more or less chronic inflammation, or to an unsuspected foreign body or new growth. In many of these cases, owing to the youth of the patient and the smallness of the parts concerned, diagnosis is all but impossible; the true cause may be guessed at but cannot be established, and that being so the proper remedy cannot be applied. I have collected from my case-books of the past eight or ten years, a number of these cases, which I purpose relating in the present paper. Their study will help to suggest, in similar cases, a possible diagnosis, and the mode in which sometimes they should and sometimes should not be treated. Cases of diphtheria are a class quite apart; for, besides the local lesion, we have to reckon with a septic condition which may diffuse itself through the system, and materially modify the course of the operation. Tracheotomy for removal of a foreign body or for chronic catarrh—a purely local lesion—is an infinitely less serious operation. On the other hand, the subsequent course of these latter cases presents difficulties and anxieties of their own, which are very troublesome. It is chiefly with these that I purpose to deal in this paper, under the term "complications," by which I mean conditions that retard or prevent the restitution of the laryngeal function and the permanent removal of the cannula. These complications are so various, and often so unexpected, that quite an exceptional interest attaches to them; no two cases ever appear to be quite alike. Some of the complications depend on the almost indispensable use of a cannula to keep the artificial opening in the trachea patent; some depend on the nature of the disease, some on accident.

Certain possible complications connected with the operation itself may just be referred to *en passant*. Occasionally the surgeon, having opened the trachea for laryngeal diphtheria, is disappointed at the non-appearance of air bubbles, or mucus or membrane; the truth being that he may have detached a layer of false membrane, or even the mucous membrane itself, from the tracheal wall, and have inserted the tube into the interval so formed. Such a mistake need not lead to any serious consequences, and can be easily remedied; the use of a dilator, and the careful swabbing out of the trachea and larynx, which I advocate as routine practice in all cases of laryngeal diphtheria, before any attempt is made to insert the tube, will effectually prevent or remedy such an occurrence. Sometimes, after swabbing out the trachea, when the membrane is very plentiful and

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very thick, pieces of it get drawn down into a bronchus during forced inspiration, and may materially interfere with the entrance of air into the ungs. Again, if much hemorrhage occur during the operation, blo od may get drawn down into the air passages, where, besides interfering with respiration, it will if left alone shortly decompose, and then give rise to septic pneumonia. In all such cases an effort must be made to remove these obstructions. Other means having failed, the instrument will be found very useful.

The death of Dr. Rabbeth, after heroically but ineffectually attempting to suck out membrane and other obstructing products of diphtheria from a tracheotomy tube, induces me to describe this instrument, and the purpose it is intended to serve, more fully than I otherwise should have done, seeing that it is figured and its use indicated in my work on "Tracheotomy in Laryngeal Diphtheria." I hold that diphtheria is largely a local disease at all stages, and that local remedies are necessary if we would successfully combat the disease. With this view I recommend that the larynx and trachea be thoroughly swabbed out with some suitable disinfectant, and that this swabbing be repeated once or twice, or oftener during the day, according to the severity of the case, as long as the diphtheritic infection continues to manifest itself by the deposition of membranous exudations. A long feather dipped in glycerine of boracic acid, or other solution, answers admirably for this purpose; its introduction causes the patient to cough, and thus the loosened membrane and other exudations are expelled. Occasionally, however, these exudations get wedged in the bronchi, and then there is more difficulty in getting them out; it is for such cases that my trachea aspirator is intended. Before using, the longer tube is soaked in hot carbolic solution, in order to make it supple. The shorter one serves as the mouth-piece. The glass bulb is filled with carbolized cotton-wool; this effectually shuts off the poison from the mouth of the operator when suction is made, for it is well known that even germs cannot penetrate through such a filter as this. The object in performing tracheotomy is not merely the introduction of a silver tube, but the removal of the foreign matter which has caused the respiratory obstruction, whatever its nature may be, and I believe this may be accomplished through a slit in the trachea held open by a dilator more easily than through a silver tracheotomy cannula. Let the surgeon, therefore, be in no hurry to insert the tube; rather, while the patient is still under chloroform, let him carefully examine the interior of the windpipe, holding it open with a dilator, and make sure that all extraneous matters have been thoroughly got rid of. In one of the cases I am about to relate, the diagnosis was difficult and uncertain, but, thanks to this

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method of dilating the tracheotomy wound and examining the trachea, the true cause of the laryngeal obstruction, a crop of warts on the vocal cords, at once became obvious.

There is a further danger to which I may perhaps just allude, though it is not a complication in the sense in which I am now using the word; I mean the danger of sudden death apart from local conditions. It depends, however, on the fact that the trachea has been interfered with. In my own experience not less than four such cases have occurred. It would seem as if this danger is associated with injury or disease of all the organs supplied by the pneumogastric nerve; thus cases of sudden death are not unfamiliar from simply washing out an empyema cavity, and I can remember a case of gastrostomy in which death rapidly followed the operation, apparently from nerve shock, and without other signs to explain it. I will only say that in all these four cases death was quite sudden and quite unlooked for; the breathing appeared to be normal until within a few moments of death, there was no struggling or foaming at the mouth, and that in the cases in which an autopsy was made, nothing was found to account for death. The interval between the operation and death varied in all the cases, ranging from four days to four months. I consider them in all respects parallel with the sudden deaths which occasionally follow on opening or washing out the pleural cavity, or even an over-distension of the pleura. They arise probably from a too powerful or too long-continued irritation of the peripheral branchlets of the pneumogastric.

The cases are classed under the following headings:—1. Acute or subacute changes due to the lesion, for which tracheotomy has been performed. 2. Chronic laryngeal changes. 3. Irritative changes due to the mere presence of a tube. 4. Accidental conditions. 5. Ulceration due to an ill-fitting tube.

1. *Acute or Subacute Changes due to the Lesion, for which Tracheotomy has been performed.*—In severe cases of diphtheria there is sometimes found deep ulceration with excavation of the mucous membrane after the false membrane has been detached, a condition which may be found at any part of the larynx. Such ulceration is usually accompanied by swelling of the adjacent sub-mucous tissue, and the ulcers themselves not infrequently become covered with florid flabby granulations, which are very troublesome to heal. This thickening of the sub-mucous tissue may also be directly continuous with that in the pharynx, and independent of ulceration. After scalds of the glottis it invariably exists for a longer or shorter period, and in greater or less intensity. It is this swelling that leads to the obstruction to breathing (not seldom fatal) which is

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known to occur after apparently slight scalds of the pharynx and larynx. At the present time I have under observation a child who was tracheotomised four or five years ago for laryngeal obstruction following a not very severe scald of the glottis. Several attempts to dispense with the tube have been made, but hitherto without success.

In the laryngitis which is occasionally associated with congenital syphilis, the lesion is of a rather different kind; it more resembles the mucous patches which occur in the mouth and about the lips. The membrane is thickened and raised owing to its infiltration with cells; the submucous tissue of course partakes more or less in the change. In older children occasionally a destructive phagedænic ulceration may occur either primarily in the larynx, or by extension from the arches of the palate or epiglottis, or from the wound. In perichondritis such as is met with in a few cases as a sequela of typhoid fever and of other febrile conditions, the inflamed mucous membrane is symptomatic of deeper changes rather than a primary condition; its course, clinical manifestations, and treatment will depend on the primary lesion. A form of laryngitis occurs also occasionally after febrile conditions, and the exanthemata are apparently due to the breaking down of exudative material which has collected in the glandular structures of the mucous membrane. These local conditions, which may all give rise to dyspnœa and necessitate the performance of tracheotomy, will generally persist for some time after the operation; the surgeon is usually brought face to face with his case when the dyspnœa is so urgent that the operation must be performed at once, and the diagnosis made afterwards. It is in such cases that the foregoing conditions become complications, the full significance of which will only become apparent at the end of a few days, when, the urgent dyspnœa having been relieved, the question of removing the cannula begins to present itself. The diagnosis of the various conditions is not very difficult, but it is essential to successful treatment. The ulceration which diphtheria occasionally produces may be suspected in the larynx, if respiration through the glottis is delayed for some time after the general disease has subsided, and more especially if a similar condition has been seen about the tonsils or palate or external wound. The expectoration of bits of membrane or of pellets of inspissated mucous with shreds of necrotic submucous tissue attached and blood-stained on the deeper surface occurs from time to time, and makes such a diagnosis almost certain. In most cases of this kind among younger children there will be considerable delay in laying aside the silver tube; if the child be poor and ill-nourished, this ulceration may heal very slowly, and months may pass before the laryngeal function is re-established. In syphilis, a diagnosis which has often to be made by a pro-

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cess of exclusion, improvement will rapidly set in on an antisyphilitic treatment, while the condition will remain stationary or become aggravated if merely treated by general remedies. Apart, however, from this method of diagnosis there may be a history of congenital syphilis, and perhaps also evident syphilitic lesions of other organs; thrush in the mouth, snuffling, condylomata about the anus, local thickenings on the long bones or bones of the skull. Any such signs would be in the highest degree suggestive of the probable nature of the laryngeal lesion, if laryngeal obstruction were found associated with one or other of the above-named conditions. In doubtful cases a mercurial course can be tried if the laryngeal urgency is not very great; a few days at most will suffice to test the value of such treatment.

The action of corrosive fluids and of hot steam or water varies with the amount swallowed, with the nature of the fluid, and with the heat of the water or steam. Occasionally diphtheria, or a membraniform inflam mation which is indistinguishable from diphtheria, may attack a throat so injured; in which case treatment will have to be in accordance with general principles, as already laid down. If the laryngeal cartilages become diseased they will have to be removed, and the ulceration of the adjoining mucous membrane will probably not begin to repair until their removal is accomplished; furthermore, the necrosed cartilage may become detached and fall into the air-passages unless it is removed. The history of a case should be carefully ascertained in all instances, not only for purposes of differential diagnosis, but for treatment also. A most troublesome point in many of these cases—one, indeed, common to all—will be the difficulty in removing the tube. A consideration of the history, the probable pathological condition of the larynx and trachea, the stage of the disease, its duration, the age of the patient, the presence or absence of secondary lung complications, are details each one of which will have to be carefully weighed and the treatment varied accordingly.

For the purposes of local applications, whether disinfectant, astringent, or solvent, to the throat, nothing is so effectual as a good spray. I would especially urge the value of a steam spray. The greater power of this over a hand spray ensures a finer pulverisation of the fluid which is being used; and it is thus more easily and more thoroughly brought into contact with every part of the diseased membrane, even up in the posterior nares; it is also more easily tolerated. In cases of diphtheria where solvents are being used to destroy false membrane, a steam spray is of first importance. By causing the patient to inhale through the larynx, or making him attempt to do so, the spray reaches the glottis and materially assists in getting rid of the viscid mucous or membrane which

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tends to collect at this spot. Occasionally, however, strong solutions of nitrate of silver are required, and these of course cannot be sprayed in. For such cases I have found a little instrument very useful. It can easily be made, and bent to any angle most convenient to the requirements of the case; consisting of a piece of glass tubing bent in the flame of a spirit lamp to the required shape, to the end of which an indiarubber mouthpiece is attached. When about to be used, a little nitrate of silver solution of the required strength is put into it; the pointed extremity is passed through the tracheal wound up to the larynx, and the fluid is blown out through the indiarubber tube. By its use the fluid is brought to bear directly on the part affected.

The undetected presence of a foreign body near the glottis is sometimes a source of trouble after an operation which has had to be hurriedly performed, and in which the history of the cause and the mode of onset are not clear. In young children the diagnosis is often very difficult, for a laryngoscope can only seldom be used. Even when the history points to the presence of a foreign body, as the probable cause, it is not always possible to detect it. In this respect the following two cases are interesting; I had the opportunity of observing both, but they were not actually under my own care:

CASE 1. *Sudden Dyspnœa; no appreciable Cause; Tracheotomy; Death; Autopsy revealed the presence of a bit of Eggshell in the Larynx.*—A small child was taken suddenly ill with laryngeal symptoms and with urgent inspiratory dyspnœa. It was playing about previously. There was no appreciable cause. When I saw it, shortly afterwards, the child was greatly distressed; its voice was gone, and death seemed imminent. Tracheotomy was at once performed, and gave instant and complete relief. A few days later attempts to remove the tube were commenced, but were quite unsuccessful. The child died in convulsions, and at the autopsy a small piece of eggshell was found adhering to the side of the larynx.

CASE 2. *Sudden Dyspnœa; Fishbone suspected as the Cause; Tracheotomy; Measles; Death; Autopsy; Impaction of Bone in the Glottis.*—A little boy, eighteen months old, taken with sudden dyspnœa while or shortly after eating fish for dinner. The cause was immediately suspected—viz: that he had swallowed a fishbone. A most careful search with the finger was made in the pharynx and upper part of the larynx, as far as possible, but without success. Tracheotomy had to be performed hurriedly. After its completion another search for the suspected bone was made, but with no better success; the tube was then inserted. The boy did well after the operation, except that his temperature remained high.

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Frequent attempts to remove the tube were made. He could neither phonate nor inspire through the glottis. An attempt to examine with the laryngoscope failed. A catheter could be passed into the mouth through the tracheal wound, but the child continued quite unable to breathe without his silver tube. The question of thyrotomy and other plans of treatment were discussed. The child's age was an element of great difficulty. However, about three weeks after the tracheotomy the child took measles, which was very prevalent at the time, and died of lung complications. At the post-mortem examination the glottis was found quite closed, with a long slender fishbone between the cords. The upper extremity of the bone projected into the pharynx, and it seemed a little remarkable that its presence was not detected by the finger when search was made for it.

These cases are of interest as showing the difficulties which beset diagnosis as well as treatment. In such cases the number of failures will certainly be lessened if the treatment of feathering out the glottis be practised as a matter of routine in all cases. But whether this treatment be adopted or not, it may be laid down almost as a rule of surgery when tracheotomy has been performed on account of a foreign body, that the persistence of the symptoms points to a persistence of the cause; little, therefore, is gained by waiting. The larynx should in all cases be examined, both from the wound and from the mouth, to make sure that the foreign body is not impacted in some part or other of the larynx, and further attempts must be made to remove it.—*R. W. Parker, M. R. C. S., in Lancet.*

(To be continued.)

Dermatology.

Edited by HENRY J. REYNOLDS, M.D., 2200 Michigan Ave.

Treatment of Eczema.—Henry J. Reynolds, M.D., Prof. of Dermatology in the College of Physicians and Surgeons, of Chicago, read a paper at the Illinois State Medical Society, of which the following is an abstract:

He said an intelligent knowledge of the principles upon which treatment should be based always suggests the form of treatment that will be applicable to each case regardless of its name or location. The pathological condition being absolutely identical in no two cases, so the treatment must always vary, and a knowledge of specified lines of treatment or combinations of drugs said to be useful with a neglect of consideration of the principles upon which treatment should be based in each individual

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case, in this, as in all other diseases, is liable to mislead. Therapeutically speaking he regards the disease as always either acute, sub-acute, or chronic, regardless of its clinical name or location, and arranges the treatment accordingly.

In the acute, as in all other acute inflammations, the great principle necessarily involved, is *rest*, which implies not only quietude of the member or part, but *rest from all irritating influences*, as scratching, irritation of lice, friction, dirt, incident to the calling of the individual, too frequent washing, etc. Soothing and protecting measures, therefore, are indicated in this stage, among which may be mentioned Carron oil, poultices, etc.

In the sub-acute, as in all other stages and forms, scratching must be strictly prohibited, as it is the most fruitful of all sources of aggravation.

He uses in this and the chronic conditions (either of which may at any time develop acute symptoms and require the treatment changed accordingly) pure, impalpably fine boracic acid as a dusting powder, having first got rid of crusts and scales by soaking with oil and washing with soap and warm water. In the chronic, however, he uses greater stimulating measures, in the way of green soap frequently rubbed in during washing. To relieve intense itching he has found nothing so effectual as a first-class letting alone.

He thinks bandaging and strapping advisable whenever practicable, and prefers the cotton roller to the rubber where there is much exudation or maceration of the skin. He reports two cases of 12 and 20 years' standing respectively, of eczema rubrum of the leg associated with varicose veins and ulceration, where many remedies had been tried without success that he cured by the application of boracic acid and bandaging, and a saline laxative internally.

He says as certain constitutional conditions predispose to the disease, and therefore necessarily aggravate or prolong it when once established, these conditions must be sought after and be corrected.

He has but little faith in the popular skin remedy, arsenic, in this or any other disease; all he knows *positively* of the remedy is that you *can* do harm with it. Chrysorobin, internally, as recommended by Stocquart, he has tried without any benefit.

Lupus Erythematosus.—*A Clinical Lecture at the College of Physicians and Surgeons of Chicago, by Henry J. Reynolds, M.D., Professor of Dermatology.*—I wish to-day to call your attention to a consideration of the disease known as lupus erythematosus.

This affection according to the classification we have adopted belongs to the class of skin diseases, known as "new growths," is found chiefly on

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the face, and as the name implies, presents to a certain extent an erythematous or reddish appearance.

I have here for your inspection a case which illustrates the disease in a most typical manner, but before examining which, however, I prefer that you get an idea of the general characteristics of the disease, and will therefore briefly refer to the same.

Lupus erythematosus is a comparatively rare affection, occurs in adult years, and chiefly in women, and is an extremely chronic affection persisting sometimes throughout life, even in spite of treatment. There is generally little or no constitutional disturbance. It usually first manifests itself as one or several reddish or brownish-red, maculo-papular lesions, situated on either side of the nose or on the cheeks, the forehead, ears, scalp and more rarely the hands and feet. As the disease progresses each lesion spreads peripherally, and in the course of months or years presents a slightly elevated, reddish or active well defined margin with a somewhat atrophied or depressed centre, covered by the characteristic scales, which are yellowish and firmly adherent, and upon removal will be found to sometimes project down into the sebaceous ducts. Though new points may develop the characteristic spread of the disease is by peripheral extension; each patch retaining its reddish active, slightly elevated margin, and leaving atrophy depression and smooth uniform scarring in the centre, giving sometimes an appearance very similar to ringworm.

The patches are circular or oval in shape, and tend to symmetrically involve both sides of the face. The subjective sensation is that of constant or occasional itching, for the relief of which the part is more rubbed than scratched. The part never ulcerates; there is never any moisture or discharge or other form of lesion more than that mentioned. The remaining scar though smooth and uniform is persistent.

The history of this case is as follows: She is æt. thirty-eight, Norwegian by birth, and otherwise healthy. The disease first made its appearance about a year ago as a small reddish spot upon the right side of the nose. A few months after a similar spot made its appearance upon the other side of the nose, and later a spot on the cheek and one back of the ear.

You will observe, as she passes around, first, the character of the lesion behind the ear, which represents the appearance of the disease in its first manifestations; as this spot has only recently developed, it is reddish and slightly elevated. You notice the lesion on the left side of the nose has gradually spread peripherally, till it has now reached a diameter of about three quarters of an inch; that while the whole lesion represents an erythematous patch, its margin slightly raised, does not pale much on pres-

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sure, and that the central portion of the lesion has become slightly depressed, paler in color, and covered with yellowish firmly adherent scales. On the right side of the nose where the disease first broke out, we find the largest lesion of all, and in addition to what we observe on the left side we find that these adherent scales send prolongations down into the sebaceous ducts, a circumstance that is also characteristic of the disease. You will also observe the tendency to symmetrical involvement of both sides of the face, a point which also tends to distinguish this from certain other diseases. There is no history of any moisture or discharge, and she states that the affected parts itch slightly at times.

Now with regard to the correctness of our diagnosis, perhaps the diseases which most resemble this are eczema, ringworm, lupus vulgaris and superficial epithelioma.

Eczema, from its great frequency and its multiform character, might first be suspected, and indeed a diagnosis of that kind has already been made of the case by a very intelligent physician. In eczema, however, we always have, at some time, a history of *moisture*, which we never have had in this case. The *itching* is more intense, and is always scratched with the nails instead of being rubbed as in this case. The most chronic cases, even of eczema, are *more acute* in character than the one before us. Eczema *does not confine itself to one locality* so constantly and continuously. It *never spreads peripherally with a tendency to clear in the centre.* If chronic it is more *variable in its behavior* than this case. The *scales are never so adherent*, the *thickening is due more to infiltration* than to new growth, it *pales more on pressure* and *does not leave a scar.*

Lupus vulgaris is a disease of *early life*, is more *nodular*, more *destructive*, it *ulcerates*, and *involves deeper structures.*

In tinea circinata, or the ordinary ringworm of the face, from the active margin, peripheral extension and clearing in the centre the appearance is somewhat similar. There is, however, *less itching* in ringworm, it *pales more on pressure*, the *border is not usually so raised*, scales *loose and furfuraceous*, not adherent, *not common on nose*, *no symmetry* of distribution, it is *not so chronic*, and we further have the *history of contagion*, *discovery of the parasite* and *no scar* as a relic of the disease.

In superficial epithelioma we very soon have some *excoriation* or abrasion, we then have *moisture*, *brown crusting*, *ulceration*, *destruction* of deeper tissues. It is not a disease of *old age* and is not *symmetrical* in its distribution; none of which are characteristic of the case before us.

It will be seen, therefore, that, while from a hasty or superficial examination, a correct diagnosis may be difficult, by carefully considering all the diagnostic points a diagnosis may be made with absolute positiveness.

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With regard to the etiology of the disease, nothing is positively known, some observers adhering to the theory of a scrofulous origin.

There being little or no constitutional disturbance in this disease, or, if any, its exact character being not definitely understood the treatment to be intelligently applied must be mainly local; and inasmuch as the local manifestations depend upon a perverted nutrition of the part, giving rise to new growth, together with, perhaps, a deposit of inflammatory exudate, it would seem that measures which tend to increase or change the character of the nutrition of the involved structures, to promote absorption, etc., would be indicated, and to this end may be used certain instruments, irritants, etc., which tend to increase the physiological afflux of blood to the part. Among these may be mentioned the daily prolonged application of hot water, rubbing in of green soap, (German) which, together with stimulating the part, also has a destructive effect upon the superficial parts. Other remedies found useful are iodine, chrysarobin, pyrogallic acid, sulphur, cantharides, etc. In this case we will for the present order the parts bathed every night for twenty minutes with water as hot as can be borne, then for five or ten minutes to be rubbed with sapo-viridis, and the whole washed off and wiped dry. A mild ointment, say 1 drachm of sulphur to 1 ounce of vaseline, will then be applied for the night. We will then on the following day, have boracic acid in fine powder applied morning and noon. This process should be modified or substituted by some other as the results seem to indicate. I have had good results when the patch was small and in its early stage, from the use of the multiple puncture by electrolytic needles as recommended for small naevi.—*Peoria Med. Monthly.*

Surgery.

Edited by G. FRANK LYDSTON, M.D., 125 State St.

Treatment of Scrofulous Cervical Glands by Excision.—Excision of scrofulous cervical glands has been a recognized mode of treatment for many years among Continental surgeons, notably by the French school. It has been rather sparingly adopted in this country, and other treatment of a less radical nature is usually practiced.

I am glad to see, however, that of late there is a growing disposition on the part of physicians to approve of, and surgeons to carry out, this most excellent method in suitable cases. My medical colleagues, both at the Royal Hospital and the Children's Hospital, have from time to time

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brought under my notice, with a view to operation, certain forms of obstinate gland swellings that resisted all the recognized modes of treatment. I have up to the present time operated in about twenty-five cases, and the result in each case has been most satisfactory. I have on more than one occasion, at this and another society, shown the patients operated on and glands removed, and to-night I have at random secured two children on whom I operated; one sixteen months, the other a year, ago. In each it is with difficulty that you can detect the seat of the operation wound, its only evidence being an indistinct white streak.

My first case was a very healthy-looking little girl, aged eleven years, whose family history was exceptionally good. She had an oval swelling the size of a pigeon's egg, situated on the left side of the neck, corresponding to a point a little above the center and toward the inner side of the sterno-mastoid. It existed for more than a year, and resisted the ordinary modes of treatment. I decided on removing the gland, and proceeded as follows:—I made an incision immediately over the center of the tumor corresponding with its long axis, and the fibres of the sterno-mastoid. Holding it between my thumb and forefinger it conveyed the feeling of being very superficial, but on dividing the upper layers of fascia instead of the gland, the fibres of the sterno-mastoid appeared in the wound. It then occurred to me that I had to deal with one of the upper set of the deep cervical chain. So I carefully separated the fibres of the muscle, divided the underlying layer of the deep cervical fascia freely, and exposed the gland placed in close contact with the carotid sheath. I now seized the mass with a small double-tumor hook, and using gentle traction, drew it toward the surface, while with careful strokes of the scalpel I liberated it from its bed of cellular tissue, thus removing it with comparative ease and very little hemorrhage. Two smaller glands, placed at either extremity of the large one, I removed in the same cautious manner, after twisting a few small arteries and washing out the wound with a solution of chloride of zinc. I bestowed great care in bringing its edges into accurate apposition by numerous points of very fine silver wire suture.

A bit of protective, a pad of antiseptic gauze and a bandage, constituted the dressing. On the third day I looked at the wound, and found it healed by direct union. There was neither swelling, nor redness, nor pain. I removed a few of the sutures and dressed the wound as before. On the fifth day I removed the remaining sutures and put a pad of cotton-wool over the part. On the day following I showed the child to the members of this Society, when the only evidence of the operation was a

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scarcely perceptible scar, which I expect through time has become still less perceptible.

[After relating several other cases, Mr. Fagan continues as follows:—]

There are a few points connected with the operation and its after-treatment to which I think it worth while to direct your attention:—

1. The incision over the gland should not be made too free; but all the underlying structures should be freely divided from angle to angle of the skin wound. When the gland is well exposed it should be seized with a small tumor hook, and steadily but gently drawn through the wound. In the majority of the cases that are suitable for this mode of treatment this is a simple process, requiring only the occasional use of the knife, a stout director or the handle of the scalpel being sufficient. When all the affected glands are removed, any ragged shreds of cellular tissue that remain should be clipped away with scissors. All bleeding points should be secured, and the wound well swabbed out with a strong solution of chloride of zinc.

2. Regarding drainage of the wound, I have had good results with and without it; still, on the whole, I think it better and safer to drain either with horsehair or very fine tubes. This is especially requisite in cases where the wound is large, and where there has been oozing of blood and difficulty of enucleating the gland.

3. As regards suturing the wound, the finest silver wire should be used It should not be passed too deeply through the lips of the wound, which should be most accurately adjusted, and the sutures should be removed not later than the third day, and sooner if the slightest inflammatory blush should appear at their points of exit from the skin. The marks that follow the suppurating tracks of the sutures are far more disfiguring than the scar from the incision.

4. As regards maintaining the parts at rest while union is taking place, this is most essential for obvious reasons. The most effectual way of securing this is, I find, by means of a night-cap with a pair of strings attached to either side; these are brought down and fastened in front to a thoracic binder, and drawn sufficiently tight to bring the head well forward on the chest. Such a form of restraint is especially necessary in the case of children, who will only remain at rest on compulsion.

5. Should inflammation attack the wound the tension should be at once relieved by removing some, if not all, of the sutures; and if there has been no drainage, a probe should be passed into its cavity at the most dependent angle, and a small tube inserted.

I have now explained to you a certain well-defined mode of treatment, as carried out by me in a considerable number of cases. To some it may

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appear very satisfactory, while to others it may seem an unnecessarily heroic method, subjecting, as it does, the patient to a certain amount of deformity, no matter how successfully carried out, and not altogether devoid of risk to the life of the patient.

In the whole range of medicine and surgery I question if there is a subject concerning which there is more diversity of opinion, regarding both its nature and treatment, than there is about what we term scrofula or struma. The various and conflicting views held at different periods by equally eminent inquirers concerning the nature of this condition; the innumerable nostrums displacing one another in rapid succession—their virtue often consisting in their novelty—is a striking proof of the unstable nature of the basis on which the pathology and thereapeutics of this disease rest. From a purely surgical standpoint I would define the term struma or scrofula as an inflammatory process attacking the tissues of a lowly vitalized organism, and manifesting itself by a slow and silent destructive action. The exciting causes that are likely to give rise to this condition in the lymphatic glands are many and obscure:—Traumatism, direct or indirect, through the lymphatics; all sources of irritation, internal as well as external—for instance, bad teeth, sore throat, bronchitis, enteritis, skin affections, exposure to cold, etc.

Any one who has seen my cases must, I think, admit that the method of treatment I have adopted is the best for those chronic cases that resist all other recognized remedies. Its superiority over the temporizing plan will appear strikingly manifest if we compare a patient restored to health after the rapid riddance of the diseased mass, and showing scarcely any mark, with another graphically described by Dr. Clifford Allbutt as "dragging on a chequered and tedious course, drifting perhaps, from doctor to doctor, consuming volumes of cod-liver oil and medicines, breaking up life and prospects by prolonged exile from home, pestered by filthy discharges, or poisoned by decay which is not discharged, disfigured by sinuses, sluggish streaks and lumps of fibrous increase, seamy scars and indurated gland remnants. Such patients, thanks to the marvelous pertinacity of life, do generally fight their way into complete or partial recovery, but at the price of permanent disfigurement; at the price of telltale corrugations in the neck; at the price, perhaps, of a deferred pulmonary phthisis, set up by absorption of the partially voided caseous products."—*John Fagan, F.R.C.S.I., in Dub. Jour. of Med. Science.*

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Obstetrics and Gynecology.

Edited by E. P. MURDOCK, M.D., 179 South Sangamon St.

Puerperal Eclampsia.*—S. O., aged 22, unmarried, was brought to Cook Co. Hospital on the morning of Sept. 2, 1884, for "suspected poisoning." Her friends assured me that she was healthy, and had complained of nothing whatever. She was found in her room, unconscious and having convulsions. A physician was called in, who gave her some hypodermic injections and had her sent to the hospital. She was taken into the medical ward under the above diagnosis. Her pupils responded to light; the convulsions, of which she had only two after her arrival at the hospital, were epileptiform in character. There was great general œdema and the most profound coma; the urine was highly albuminous, and she was pregnant. The diagnosis of eclampsia was made, and the patient transferred to the obstetric ward, where she came under my care.

Dilatation was begun and labor induced as rapidly as possible. About five o'clock in the afternoon the patient had another severe convulsion; a pair of small forceps was applied and she was soon delivered of a six-months' fœtus, dead. The fœtal heart was not heard, but the death of the fœtus was evidently quite recent. The placenta was easily removed, and over the uterine surface were large patches of fatty degeneration. The patches were covering about half the area of the placenta, were somewhat firm to the touch, raised, and whitish in color.

The subsequent management of the case consisted in measures aimed at the great œdema which rapidly subsided. A single intra-uterine douche after delivery, followed up by vaginal douches two or three times a day. She had no more convulsions, and made a rapid recovery from her more severe symptoms, but the anæmia persisted for some time.

For each hypodermic injection she received, an abscess developed, for which she was transferred to the surgical department, Sept. 15.

Sept. 2. P.M. Pulse 125, temperature 100.6. Ol. tiglii, gtt. ij, ext. jaborandi fl. 3j, and spts. frumenti 3j, every four hours.

3d. A.M. Pulse 100, temperature 88.5. Sweat profusely during the night, and œdema much less. Remains quite stupid, but can be roused. Urine, albumen 30 per cent, a deposit of mostly hyaline and some granular casts.

4th. A.M. Pulse 118; is quite rational and has had no more convulsions.

*Reported by Dr. W. H. Weaver, late Resident Physician to Cook Co. Hospital, Visiting Physician to West Side Free Dispensary.

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5th. A.M. Œdema entirely disappeared.

6th. A.M. Urine, alb. 20 per cent, casts as above.

7th. A.M. Pulse 115, temperature 100.3; complains of severe headache, for which sol. pot. bromide and chloral was ordered; repeated p. r. u.

8th. A.M. Pulse 108, temperature 99.6. Tr. ferri chlor.; m. in a glass of milk t. i. d.

9th. A.M. Pulse 112, temperature 100.2; headache still continues.

10th. A.M. Pulse 103, temperature 98.5; headache is not relieved by the medicine; amy nit. relieves immediately. ℞ Amyl nit. gtt. ij, etheris gtt. x, spts. frumenti ʒj; M. every four hours.

10th. P.M. Has no more headache.

11th. A.M. Pulse 96, temperature 85; urine, alb. 18 per cent. Stop tr. ferri chlor. ℞ Ferri et pot. tart. gr. v, hydrarg. chlor. mite. gr. ½; t. i. d.

Patient improved steadily till Sept. 15, when there was only a trace of albumen in the urine. She was sent to the surgical department for the treatment of her hypodermic abscesses. The hypodermic injections resulted in abscesses probably because of the very great œdema, which prevented absorption. Patient was discharged, recovered, Nov. 26, 1884.

The most important features in the case are its early occurrence in pregnancy—6th month; second, the suddenness of the most appalling condition in an apparently healthy young woman; third, the fatty degeneration of the placenta.

Puerperal eclampsia occurs most frequently during labor or just before, but rarely as early as the sixth month; and when it does, its coming is announced by more or less unmistakable symptoms. A case is reported in the last number of the *Medical Record* by Dr. W. A. Hulse, of Bay Shore, N. Y., of a lady, aged 28, who was found two months before delivery, to be suffering from general anasorca and some symptoms of uræmic poisoning. She received appropriate treatment and was delivered at full term. She had four convulsions during labor, and was comatose for awhile, but rapidly recovered. The case probably would have gone on to convulsions at the first but for the treatment.

Our patient was not seen until she was far advanced in the disease; indeed the entire trouble seemed to have developed in a single night; although she had but few convulsions, the coma was profound, and was probably due to œdema of the brain and effusion into the ventricles. The œdema was so great that the skin seemed to be distended to its utmos capacity.

The degeneration of the placenta is said to be a frequent cause of irritation to the nervous system and kidneys, resulting in eclampsia. It

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existed in this case to a remarkable degree, and must have begun at least before the symptoms developed.

Rapid Dilatation of The Uterine Canal.—D. Tod Gilliam, in the last number of the *Medical Record*, enters a protest against the miscellaneous use of sounds as uterine dilators. In order to introduce a sound the cervix must be fixed by a strong tenaculum. The cervix is extensible, and under the opposing forces of the tenaculum and the dilator, often becomes much elongated. This may mislead the operator, and he may think he has passed the internal as when it has been pushed before the point of the dilator, but in that case the sound will not remain fixed, as if in a canal, and will rebound when the pressure is removed. The use of sounds is faulty, in that it necessitates the elongation of the cervix. The objects to be attained in rapid dilatation are the rupture of unnatural bands of muscular and connective tissue, without laceration of the surfaces. These are most effectually accomplished by use of expanding blades, such as the Ellinger dilator, which is the most perfect, as the action of the blades is paralel.

In performing the operation, the patient is thoroughly anesthetized, the dilator is introduced with the blades closed, taking care that the blades do not slip and lacerate the os; they are separated gradually by increasing the pressure on the handles. As a rule dilatation should be carried to the full capacity of the instrument, which will be about an inch, and give a diameter of about one-half or two-thirds of an inch. After the operation an antiseptic should be applied to the surfaces, anodynes given and rest enjoined for a time.

Extra-Uterine Pregnancy.—In a recent number of the *Brit. Med. Jour.*, Mr. Lawson Tait reports three cases of tubal pregnancy, with consequent rupture of the tube, in which laparotomy was performed successfully. Mr. Tait has now saved eight women out of nine in whom a similar condition existed. This is a remarkable record, and we do not know which most to admire, the accuracy of the diagnosis or the promptness with which the emergency was met. In Mr. Tait's opinion, all cases of extra-uterine pregnancy are of the tubal variety.—*N. Y. Med. Jour.*

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Eye and Ear.

Edited by J. E. HARPER, M.D., 163 State St.

Transplantation of Skin-Flaps without Pedicle.—At a recent meeting of the Academy of Medicine, in Ireland, Mr. Swanzy read a paper on transplantation of skin-flaps without pedicle, for the cure of cicatricial ectropion. He reviewed the steps of the proceeding as usually practised, and gave particulars of six operations he had recently performed, four of them successful, and two unsuccessful. The successful cases were exhibited. In addition to the points generally regarded as important, he drew attention to the following:

1. It was desirable that the wounded surface on the eyelid should be made as extensive as possible, by the dissection of the everted lid being carried to the fullest extent. It was not sufficient, as usually recommended, to carry the dissection only so far as to bring the free margin of the eyelid being operated on into contact with the free margin of its fellow; but the dissection of the lid from the surface underneath to which it was attached should be gone on with until, on reflection, the free margin reached up to beyond the eyebrow, if it were the lower lid, or as far as or below the infra-orbital margin, if it were the upper lid. The object of this was to provide for the inevitable shrinking which took place in the transplanted flap, so that the ultimate size of the eyelid might not be less, or much less than normal. This point had not before been mentioned.

2. With regard to securing the flap in its new position by sutures, it would be much better if sutures could be avoided, as they caused suppuration at each point. The author had no experience of methods of securing the flap without sutures. If sutures were used, they should be of fine silk or of fine platinum wire, and only so many as sufficed to keep the flap in its place. Catgut sutures were not suitable, as they did not hold long enough to enable the flap to become adherent. A large number of sutures were unnecessary, and caused a line of suppuration around the margin of the flap; but platinum wire seemed to cause litlle suppuration.

3. With regard to the dressing, carbolic acid should not be used in any form, being apt to irritate the delicate skin-flap, and increase the liability to peeling off the epidermis. He did not agree with Wolfe, that the so-called antisepticism "has no place in ophthalmic surgery." In this proceeding, the dressings should be antiseptic, but they should be also non-irritating. Boracic acid and sero-sublimate were among the suitable applications. Finally he pointed out that where the epidermis had not

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peeled off the shrinking was slight in comparison with where it came away and where the rete Malpighii had to throw out a new cuticle.—*Am. Med. Abstract.*

Salicylate of Eserine in Phlyctenular Keratitis.—The following formula the author finds to yield very satisfactory results in the treatment of inflammation of the cornea of children: ℞ Salicylate eserine, grs. ij, aqua, ʒ ss. M. Sig.—One or two drops once a day; drop into the eye.—*Med. Bulletin.*

A Peculiar Effect of Digitalis upon the Eye-sight.—The case is related in the *Ber ght der Rudolph Stiftung vom Jahre* 1883, of a man suffering from heart-disease following rheumatism. The urine contained a small amovnt of albumen. The patient was placed upon three grains of digitalis leaves, in the form of infusion, per diem. About a fortnight later the man complained of weakened vision, there seeming to be a cloud before his eyes. He attributed it to the digitalis, saying that he had been affected in the same way on a previous occasion while taking the drug. He could see better in the evening than by daylight. The pupils were not especially dilated, and nothing abnormal about the eyes could be detected on examination. There were no other symptoms of digitalis poisoning, such as nausea, etc. The administration of the drug was discontinued, and in a few days there was a marked improvement in the sight.

Editorial.

AMERICAN MEDICAL ASSOCIATION.

THIRTY-SIXTH ANNUAL SESSION HELD AT NEW ORLEANS, LA., APRIL 28, 29 AND 30, AND MAY 1, 1885.

TUESDAY, APRIL 28TH—FIRST DAY.—The Association met this morning, and was called to order at eleven o'clock by DR. SAMUEL LOGAN, of New Orleans, Chairman of the Committee of Arrangements.

A prayer was offered by the Rev. B. M. Palmer, D.D.

DR. LOGAN then introduced the President, Dr. Henry F. Campbell, of Augusta, Ga., and afterward delivered the Address of Welcome, which was timely and well received.

THE PRESIDENT invited the ex-Presidents to take seats on the platform, and Drs. T. G. Richardson, of New Orleans, N. S. Davis, of Chicago, and J. M. Toner, of Washington, responded.

DR. CAMPBELL then delivered the Annual Address of the President.

He asked early and systematic attention to the problem of forensic medicine, including the medical witness, the medical expert, and the medical defender, and suggested that a new section be formed to which all discussions, papers, and reports concerning the relations of medical men to tribunals of law could be referred.

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On motion of DR. BRODIE, of Detroit, a vote of thanks was tendered to the President, and the address was referred to the Committee on Publication.

On motion of DR. QUINBY, of Jersey City, it was agreed that that part of the President's address relating to forensic medicine, be referred to a committee of five, to be appointed by the Chair, and to report within the present meeting.

The report of the Special Committee, Dr. Austin Flint, Sr., of New York, Chairman, on the death of Samuel D. Gross, was read by DR. T. G. RICHARDSON, of New Orleans, and referred to the Committee on Publication.

DR. JOHN BILLINGS, U.S.A., in the absence of Austin Flint, Sr., reported the success of the Special Committee in securing an appropriation from Congress for the erection of a fire-proof building for the Army Medical Museum and Library at Washington.

Dr. Billings reported the action which had been taken concerning the next International Medical Congress by the Executive Committee, in conformity with resolutions adopted at the last annual meeting of the Association, which has received publication in the medical journals throughout the United States.

On motion of DR. KELLER, of Arkansas, the report was made the special order for Wednesday at 12 noon.

The report of Dr. A. L. Gihon, on the subject of the Erection of the Monument to Dr. Benjamin Rush was presented, and on motion by DR. TONER, of Washington, made the special order for Friday morning.

The following gentlemen were made invited guests:

Drs. Edward Jones, A. B. Miles, and C. J. Bickham, of New Orleans; A. E. Forte, of Philadelphia; J. J. Gauthereaux, of St. James, La.; and James R. Scarborough, of Clinton, Ky.

A communication from the Medical Association of South Carolina, on the Discovery of the Anæsthetic Properties of Sulphuric Ether, was presented by Dr. R. A. Kinloch, of Charleston, and on motion by DR. BEVERLEY COLE, of San Francisco, was referred to the Section on Practice of Medicine and Materia Medica, with the request that it consider the subject, and report to the Association.

The Association then adjourned, to meet on Wednesday morning at ten o'clock.

WEDNESDAY, APRIL 29TH—SECOND DAY.—The Association was called to order at 10 A.M. by the PRESIDENT, and prayer was offered by the REV. J. K. GUTHEIM. D.D.

The Secretary announced the following Committee on Nominations:

John Cochrane, Alabama; R. A. Kinloch, South Carolina; L. P. Gibson, Arkansas; R. B. Cole, California; H. O. Walker, Michigan; C. C. Wyckoff, New York; William Pierson, New Jersey; W. H. Phillips, Ohio; R. S. Sutton, Pennsylvania; D. W. Krouse, Iowa; J. A. White, Virginia; J. H. Murphy, Minnesota; N. T. Nelson, Illinois; T. G. Richardson, Louisiana; C. H. Shackford, Massachusetts; Job W. Smith, Florida; J. B. Robertson, Texas; S. S. Riddel, Wisconsin; E. F. Upham, Vermont; A. Y. P. Garnett, District of Columbia; L. D. Waterman, Indiana; G. W. Baldwin, Kansas; B. F. Coleman, Kentucky; S.

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C. Gordon, Maine; R. J. Nunn, Georgia; J. McAchran, Wyoming; Joseph R. Smith, U. S. Army; George Peck, U. S. Navy; John Godfrey, U. S. Marine Hospital Service; D. T. Nelson, Illinois; John S. Lynch, Maryland; G. M. Taylor, Mississippi; Le Grand Atwood, Missouri; R. C. Moore, Nebraska; W. E. Anthony, Rhode Island; D. J. Roberts, Tennessee; J. H. Pipes, West Virginia; C. J. O'Hagan, North Carolina.

The next order of business was the Address of the Chairman of the Section in Practical Medicine, Materia Medica, and Physiology, by DR. H. D. DIDAMA, of Syracuse, N. Y. Special attention was directed to only two topics which had most recently engaged the observation of the profession, namely the Comma Bacillus and the Hydrochlorate of Cocaine. The speaker then reviewed the present aspect of the question of the relation which cholera and the comma bacillus sustain to each other, and then referred somewhat extensively to the general subject of bacteriology, and to the little help which it had given to the art of healing.

On motion the address was referred to the Committee on Publication.

The Address of the Chairman of the Section in Obstetrics and Diseases of Women, was delivered by DR. R. S. SUTTON, of Pittsburgh, Pa., the subject of which was on Ovariotomy. He insisted, as in all former papers, upon greater care in the surroundings of all intra-abdominal operations, and in further proof of his position, pointed to the admirable results obtained by John Homans, of Boston, and Robert Battey, of Rome, Ga., both of whom used the carbolic spray. He stated that for himself he did not use the spray, but looked upon cleanliness and Listerism as linked so closely together that they might be said to be inseparable, for Listerism is the gospel of cleanliness.

Mr. Lawson Tait had said to him: "I have sold all my right, title, and interest in Listerism with my tea-kettle to Battey." At the close of his address, Dr. Sutton referred to Dr. J. Marion Sims as one whose name was synonymous with the surgery of women, beloved of his own countrymen, and honored by the entire surgical world.

On motion by DR. W. W. POTTER, of Buffalo, N. Y., the thanks of the Association were tendered to Dr. Sutton for his address, and the address was referred to the Committee on Publication.

DR. W. C. VAN BIBBER, of Baltimore, then delivered an address containing suggestions in regard to the construction of a health city in Florida, or peninsular and sub-peninsular air and climate.

The International Medical Congress question was now in order and DR. SHOEMAKER, of Philadelphia, opened the discussion by protesting against the action the Committee had taken, that they had exceeded their authority, that they were simply a Committee of Arrangements, that they had no right or authority to appoint officers, sections, etc. Several resolutions intended to obviate the difficulty were offered, and after an animated and interesting discussion by Drs. Cole, of California, Quinby of New Jersey, Daniel of Texas, Billings of Washington, Gabriel of Ohio, King of Missouri, Roberts of Philadelphia, Landers of Tennessee and Ghent of Texas, a resolution by Dr. Keller, of Arkansas, whereby the present Committee be enlarged by appointing one additional member of the same from each State and Territory, and from the Army and

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Navy and Marine Hospital Service and the District of Columbia was adopted. The Committee as thus enlarged to be empowered to review, alter and amend the action of the present Committee as they deem best.

The Association then adjourned to meet on Thursday at 10 A. M.

THURSDAY, APRIL 30—THIRD DAY.—The Association was called to order by the PRESIDENT, and prayer offered by the REV. W. H. WATERS, D.D.

The Standing Committee on Meteorological Conditions and their Relation to Prevalence of Disease, made a report which was accepted and the Committee continued.

DR. DAVIS reported concerning the subject of the Collective Investigation of Disease in co-operation with the Committee of the British Medical Association and the Committee of the International Medical Congress.

The report was adopted and referred for publication.

DR. N. S. DAVIS, Chairman of the Committee appointed last year to make some Declarative Interpretation of Certain Points in the Code of Ethics, submitted the following report in the form of a preamble and resolutions:

WHEREAS, Persistent misrepresentations have been and still are being made concerning certain provisions of the Code of Ethics of this Association, by which many in the community, some in the ranks of the profession, are led to believe its provisions excludes persons from professional recognition, simply because of difference of opinion or doctrine; therefore be it

Resolved, That Clause 1, Article IV., in the National Code of Medical Ethics, is not to be interpreted as excluding from professional fellowship, on the ground of difference in doctrine or belief, those who in other respects are entitled to be members of the regular medical profession, neither is there any other article or clause in said Code of Ethics that interferes with the exercise of the most perfect liberality of individual opinion and practice.

Resolved, That it constitutes a voluntary disconnection or withdrawal from the medical profession proper to assume a name indicating to the public a sectarian and exclusive system of practice, or to belong to an association or party antagonistic to the general medical profession.

Resolved, That there is no provision in the National Code of Medical Ethics in any wise inconsistent with the broadest dictates of humanity, and that the article of the Code which relates to consultations cannot be correctly interpreted as interdicting, under any circumstances, the rendering of professional services whenever there is pressing or immediate need of them; on the contrary, to promptly meet the emergencies occasioned by disease or accident, and to give the helping hand of assistance without unnecessary delay is a duty fully enjoined on every member of the profession, both by the letter and the spirit of the entire Code, but no such emergencies or circumstances can make it necessary or proper to enter into professional consultation with those who have voluntarily discon-

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nected themselves from the regular medical profession in the manner indicated by the preceding resolution.

(Signed) N. S. DAVIS, Chicago.
A. Y. P. GARNETT, Washington.
H. F. CAMPBELL, Augusta, Ga.
AUSTIN FLINT, SR., New York.
J. B. MURDOCH, Pittsburgh.

This report was adopted unanimously as an interpretation of certain clauses in the Code.

The Address of the Chairman of the Section on Surgery and Anatomy was then delivered by DR. DUNCAN EVE, of Nashville, Tenn.

The first part of the address contained a rhetorical reference to surgery before anatomy was understood, and to what it had accomplished from the days of the ancients down to the present time. Special mention was then made to some of the noteworthy contributions which had been published during the past year.

The address of the Chairman of the Section on State Medicine by DR. E. W. SCHAUFFER, of Missouri, was read by title and referred to the Committee on Publication.

The report of the Treasurer showed a balance in the treasury of $932.11, and an addition of one hundred and twenty-five members.

According to the new method adopted last year, the Librarian was authorized to send a report directly to the editor of the *Journal*.

DR. J. M. TONER read the Report of the Committee on Publication, which included the Report of the Board of Trustees of the *Journal*, in which it appeared that at the close of the second year the *Journal* is free from debt, and that it commands an income which, if not diverted elsewhere, will enable the editor, with his corps of assistants, to make it one of the foremost journals in the land. The total income for the second year was $21,000, and the total expense, except editorial salary, twelve thousand odd dollars.

The publication of the *Journal* will be continued in Chicago.

Dr. Davis will remain editor, having withdrawn his resignation at the earnest and unanimous request of the Board of Trustees.

In response to repeated calls, Dr. Davis addressed the Association, and spoke at some length concerning the requirements to be met, and the obstacles to be overcome in making a first-class medical journal, all of which could be accomplished by prudence and perseverance.

DR. N. H. REED, of Mansfield, O., offered the following resolution, which was adopted:

WHEREAS, There is no stimulus for original research at present in the Association,

Resolved, That a First and Second Honor Prize be offered for the best and second-best paper in each section at the next meeting of the Association, and that three judges be appointed, no two of which shall be from any one State; and said papers shall not occupy more than thirty minutes.

The following resolution, offered by DR. J. B. ROBERTS, of Philadelphia, adopted by the Section in State Medicine, and referred to the Association, was read and laid upon the table temporarily.

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Resolved, That the Section in State Medicine earnestly advocates establishing in every State and Territory, Boards of Medical Examiners, who shall examine all practitioners, and whose license shall be the only license to practice medicine.

On motion of DR. J. M. TONER, of Washington, the Report of the Committee on Erecting a Statue of Benjamin Rush was taken from the table and read by the Secretary. The report closed with the following resolution, which was adopted, and the following committee appointed: Drs. A. L. Gihon, of Washington; Henry Smith, of Philadelphia; R. A. Kinloch, of Charleston; S. C. Gordon, of Maine; J. H. Murphy, of Tennessee; M. H. Henry, of New York.

Resolved, That this Association undertake to erect a statue in the city of Washington by members of the profession in the United States, and that the necessary funds be obtained by subscriptions limited to one dollar, and by voluntary donations from such others as may be interested in the matter.

The Secretary announced the following Committee on that part of the President's Address relating to Forensic Medicine: Drs. I. N. Quinby, of New Jersey; C. Scott, of Cleveland, O.; W. W. Dawson, of Cincinnati, O.; F. E. Daniel, of Texas; J. V. Shoemaker, of Pennsylvania; Eugene Foster and H. F. Campbell, of Augusta, Ga.

DR. R. A. KINLOCH, Chairman, read the following Report of the Committee on Nominations, which was adopted:

President—Dr. William Brodie, Detroit, Mich.

Vice-Presidents—Drs. Samuel Logan, New Orleans; A. Y. P. Garnett, Washington; Charles Alexander, Wisconsin; W. F. Peck, Iowa.

Permanent Secretary—W. B. Atkinson, Philadelphia.

Treasurer—Richard J. Dunglison, Philadelphia.

Librarian—C. H. A. Kleinschmidt, Washington, D. C.

Officers of Sections: Practice of Medicine—James T. Whittaker, Cincinnati, Chairman; B. L. Coleman, Kentucky, Secretary. *Section on Obstetrics*—S. C. Gordon, Maine, Chairman; J. F. Y. Paine, Texas, Secretary. *Section on Surgery and Anatomy*—Dr. N. Senn, Milwaukee, Wis., Chairman; H. H. Munn, Missouri, Secretary. *Ophthalmology, Otology, Laryngology*—Dr. Eugene Smith, Detroit, Mich., Chairman; J. Fulton, Minnesota, Secretary. *Diseases of Children*—Dr. W. D. Haggard, Tennessee, Chairman; Dr. W. B. Lawrence, Kansas. Secretary. *Dental and Oral Surgery*—Dr. J. H. Marshall, Illinois, Chairman; Dr. J. E. Baldwin, Illinois, Secretary. *Committee on State Medicine*—Dr. J. S. Rauch, Illinois, Chairman; Dr. F. E. Daniel, Texas, Secretary. *Committee on Necrology*—Dr. J. M. Toner, Washington, Chairman.

Judicial Council—Dr. R. A. Kinloch, South Carolina; D. D. Sanders, Tennessee; T. G. Richardson, Louisiana; D. A. Ketchum, Alabama; George Beard, West Virginia; J. M. Toner, District of Columbia; A. M. Pollak, Pennsylvania.

Place of Meeting—St. Louis, Mo., on the first Tuesday in May, 1886.

The following members were added to Committee on International Congress:

Drs. D. A. Linthicum, Arkansas; George A. Ketchum, Alabama; A. R. Smart, Michigan; J. V. Shoemaker, Pennsylvania; F. A. Sim, Tennessee; J. W. McLaughlin, Texas; A. Y. P. Garnett, District of Columbia; S. C. Gordon, Maine; John S. Lynch, Maryland; Ellsworth Eliot, New York; X. C. Scott, Ohio; W. C. Dabney, Virginia; Nicholas Senn, Wisconsin; Robert Battey, Georgia; J. W. Dupree, Louisiana; W. E. Anthony, Rhode Island; R. D. Murray, Florida; E. P. Cook,

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Illinois; J. B. Hamilton, Marine Hospital Service; R. B. Cole, California; Charles Denison, Colorado; F. W. Beard, Indiana; D. W. Stromont, Kansas; L. P. Bush, Delaware; A. H. Wilson, Massachusetts; William Pierson, New Jersey; R. A. Kinloch, South Carolina; W. H. Watson, Kentucky; E. French, Minnesota; N. F. Essig, Missouri; R. C. Moore, Nebraska; G. Baird, West Virginia; Surgeon-General Murray, U. S. Army; Surgeon-General Gunnell, U. S. Navy.

Dr. Quinby, of Jersey City, offered the following resolution, which was adopted:

Resolved, That the Committee appointed in pursuance of a resolution adopted by this Association, April 30, 1885, to constitute an addition to the original committee of seven, previously appointed, to invite and make arrangements for the meeting of the International Medical Congress, to be held in Washington, D. C., 1887, be and the said Committee is hereby authorized and empowered to select a Chairman and Secretary, and to fill all vacancies that may occur by death or inability to attend on the Committee, and to appoint the officers of the Congress.

The Committee met immediately to make preliminary organization.

Dr. Brodie resigned from the Judicial Council. Resignation accepted and referred to Committee on Nominations.

SECTION ON PRACTICE OF MEDICINE.

Tuesday, April 28th—First Day.—Dr. Didama, of Syracuse, N. Y., Chairman, called the Section to order.

Dr. Bulkley, of New York, read a paper on Carbuncle. He objected to incision, because of the danger from pus being absorbed, which does not occur when the carbuncle is allowed to open naturally. He was opposed to poultices, and gave calcium sulphite in quarter-grain doses in gelatine-coated pills every two hours, magnesia sulphate in laxative doses three times a day, and tonic doses of sulphate of iron; and an application of solid extract of ergot 2 drachms; oxide of zinc, one drachm; rose-water ointment, two ounces, upon lint, to the carbuncle, which reduces pain and cuts short the disease.

Dr. Hebbard, of Indianapolis, found that oleate of morphia, applied every two hours, cuts short carbuncle to a few days' duration. He did not incise.

Dr. Lynch, of Baltimore, indorsed Dr. Bulkley's plan, but applied dilute citrine ointment.

Dr. Shoemaker, of Philadelphia, did not incise carbuncle, unless there was a considerable quantity of pus. He indorsed Dr. Bulkley's treatment and did not get good results from oleates.

Dr. Savage, of Tennessee, painted a ring of collodion around the carbuncle with good results.

Dr. A. F. Patte, of Boston, Mass., read a paper upon the Percuteur: its Uses in Diseases of the Nervous System, and exhibited an instrument.

Dr. N. Harvey Reed, of Mansfield, O., read a paper on Hydatid Tumors.

Dr. Jakins, of Iowa, in the discussion, thought it strange that the hydatids should have occurred in the brain and not in the liver, and was inclined to doubt the correctness of the diagnosis.

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Dr. Whitaker, of Cincinnati, thought the microscopic examinations should have been more complete before a diagnosis was made.

Dr. Whitaker, of Cincinnati, then read a paper entitled An Attempt at Radical Treatment of Tuberculosis. He had in five cases injected one-eighth of a grain of bichloride of mercury into the consolidated portion of the lung daily, but without favorable result.

A paper on the Hypodermatic Injection of Oil, was read by Dr. John V. Shoemaker, of Philadelphia.

SECTION ON SURGERY.

Tuesday, April 28th—First Day.—The Section was called to order by Dr. Duncan Eve, of Tennessee, Chairman, and Dr. Henry J. Reynolds, of Chicago, was elected Secretary, *pro tem.*

Dr. John B. Roberts, of Philadelphia, read a paper on False Doctrines in the Treatment of Fractures, referring first to errors by the invariable use of the primary bandage, and by the use of passive motion too late or too early. He said splints were often left on too long; there was more damage done by letting it alone than by exploring in fractures of the skull. He also referred to fractures of the nose, clavicle, humerus and elbow-joint. The use of the interosseous pad in the forearm he maintained did not do what was claimed for it. He believed that as a diagnostic point measurement was not of as much value in the lower extremities as was generally supposed.

The paper was discussed by Drs. Peck, of Iowa; Quinby, of New Jersey; Budd, of Missouri, Murphy, of Minnesota; Bird and Cook, of Illinois; Elliott, of Georgia, and Francis V. White, of New York.

The next paper was by Dr. Verity, of Illinois, and entitled the Treatment of Compound Fractures by Free Drainage and Wiring of Bones. He claimed that no fragments should be removed unless they were sources of irritation, that all should be wired together and free drainage established. He related several very interesting cases, which he illustrated with drawings.

The discussion of the paper was postponed till the next session. The Section then adjourned until Wednesday.

Wednesday, April 29th—Second Day.—The meeting was called to order by the Chairman, Dr. Eve, of Tennessee.

Dr. P. E. Archinard, of Louisiana, was elected Secretary, *pro tem.*

Dr. H. O. Marcy, of Massachusetts, read a paper entitled Do we Find from Micro-Organisms in Enclosed Cavities a Hitherto Unsuspected Danger to Surgical Lesions?

He reported several interesting cases in which micro-organisms were found in ovarian fluids.

The paper was discussed by Drs. Byrd, of Illinois, Peck, of Iowa, and Hurst, of Illinois.

Dr. Senn, of Milwaukee, Wis., then read a paper on the Surgical Treatment of Cysts of the Pancreas. The paper was summarized in conclusion as follows:

1. Cysts of the pancreas are true retention cysts. 2. Cicatricial contraction, or obliteration of the common duct or its branches, and impacted calculi, are the most frequent causes of cysts of the pancreas. 3. A posi-

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tive diagnosis of a cyst of the pancreas is impossible. A probable diagnosis between it and some other kind of cysts amenable to the same surgical treatment is adequate for all practical purposes. 4. The formation of a pancreatic fistula under antiseptic precautions recommends itself as the safest and mest expedient operation in the treatment of cysts of the pancreas.

The next paper was by DR. RANSOHOFF, of Cincinnati, O., entitled Two Ovariotomies on the same Patient.

It was discussed by Dr. Reid, of Ohio, and Dr. J. H. Warren, of Massachusetts.

The next paper was on Giant Growth of the Lower Extremities.

DR. R. H. JENKINS, of Georgia, then read a paper entitled Report of a Case of Necrosis of Tibia and Fibula of Ten Years' Duration—Operation and Recovery.

THURSDAY, APRIL 30TH—THIRD DAY.—The Section was called to order by the Chairman, and DR. HENRY J. REYNOLDS, of Chicago, Ill., was elected Secretary, *pra tem.*

The first paper was by Dr. A. Y. P. Garnett, of Washington, D. C., entitled Colo-Proctitis Treated by Hot-Water Douche and Stretching or Division of Sphincter Ani.

It was discussed by Drs. Dawson, of Ohio, Ransohoff, of Ohio, Peck, of Iowa, and Byrd, of Illinois.

A paper by DR. H. L. GETZ, of Iowa, on A New Combined Trocar and Canula, and Aspirating Needle, was referred to the Committee on Publication, as the writer was not present.

A case of fibroma of the scalp was presented by DR. OWENS, and discussed by Drs. Dawson, Kinloch and Warren.

The Section then adjourned.

SECTION ON OBSTETRICS.

TUESDAY, APRIL 28TH—FIRST DAY.—The Section was called to order, DR. R. S. SUTTON, of Pittsburg, Pa., Chairman.

DR. WILLIAM H. WATHER, of Louisville, Ky., read a paper on the Treatment of the Secundines in Abortion and Labor.

Medical literature contains many instances of death from retained placenta and membranes.

Dilatation can be made with metallic or rubber dilators, and the membranes should be removed by curette or forceps. A curette can be improvised if not at hand. If the uterus does not expel the placenta in thirty minutes, we should assist it by manipulation. If we forcibly remove the placenta sooner than fifteen minutes after the birth of the child, there is danger of coagulation not being completed.

It was discussed by Drs. Chadwick, Green, Sinclair, Carroll and Wather. The general sentiment favored dilatation with the fingers in retained placenta, in preference to instruments, especially in the later months of pregnancy.

DR. W. W. POTTER, of Buffalo, read a paper on Parametric Abscess, and related a case in which there was the rapid formation of a large abscess, attended with improvement under the use of iodoform. He main-

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tained that the expectant treatment of yesterday gave place to evacuation to-day, and that delay was always dangerous.

Dr. C. Fenger, of Chicago, read a paper on Chronic Peri-uterine Abscess: its Treatment by Laparotomy.

If the abscess is deep or behind the uterus, laparotomy is often necessary. He used the thermo-cautery to make the incision. The antiseptic precaution should be employed. He preferred iodoform externally and boracic acid for injections. The advantage of laparotomy over vaginal operation was manifested by the fact that the former gave a better opportunity for reaching the seat of the trouble.

It was discussed by Drs. Engelmann, Gordon, Reeve, Potts, Jaggard and Sutton.

Dr. George French, of Minneapolis, read a paper on How Soon after Exposure to Sepsis may the Accoucheur resume Practice.

He dwelt on the crime of carrying the poison to a patient, and read a number of letters from authorities in England and on the Continent, some asserting time to be essential, others that a thorough cleansing and antisepsis was the desideratum.

Dr. Robert Battey, of Rome, Ga., thought a consciousness of the danger of carrying septic matter was one of the greatest safeguards. He believed time or ventilation had something to do with it.

Dr. Hoppler, of Vermont, thought cleanliness godliness itself in obstetrics.

Dr. French believed time salutary, but disinfection more important.

Dr. J. A. Y. Payne, of Galveston, Texas, reported a case of Abdominal Tumor, of the hard fibroid variety, of enormous dimensions. The following were the measurements when the case came to him: Epigastric, 50 inches; umbilical, 51 inches; hypogastric, 51½ inches. Ten days later the tumor had increased half an inch. One year later the measurements were 26¼ inches, 20½ inches and 22 inches respectively. He used ergot, giving as much as ten grains hypodermically twice a day.

The Section then adjourned.

Wednesday, April 29th—Second Day.—Dr. N. J. Nunn, of Savannah, Ga., read a paper on the Multiple Speculum Uteri and an Improved Dressing Forceps.

The speculum had five blades, and filled all the requirements of a Cusco, a Graves and a Sims. The speculum and dressing forceps were exhibited.

Dr. G. Otto, of Arkansas, exhibited a speculum. It was first intended to be used only in the Sims position. He had found, however, that it answered equally as well in the dorsal. The connecting medium was entirely out of view.

Dr. J. Engelmann, of St. Louis, spoke concerning the Improved Technique in Gynecological Operations, Minor and Major, and said his manner of operating was similar in many ways to the European, though in some points original. It was entirely different from the American way of operating. He claimed for it asepsis, or cleanliness, simplicity and rapidity. The plan is to make operations on the vaginal tract under the hot vaginal douche, and use no sponge whatever. He has used no

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sponges for years. He showed a new Simon speculum, quite large and broad, stout and convex, which widens the vagina and draws it down by pressure in the perineum. He recommended asepsis in major and minor operations, and careful attention to details.

Dr. T. M. Healy, of Cumberland, Md., showed a speculum, the object of which was to do away with an assistant, which was very desirable in country practice.

Dr. Henry O. Marcy, of Boston, read a paper on the subject of Speculi.

Dr. Henry O. Marcy also read a paper on the Role of Bacteria. He had a number of years ago maintained in the Boston Medical Society that Delivery should be carried on with as much antiseptic precaution as an extensive surgical operation. He found then no supporters; now a number of leading schools taught that antiseptic injection should be made in every case as routine practice. In the majority of normal labors there is a solution of continuity, cervical, vaginal or perineal. The physiological state is so distorted that it was akin to a pathological one. In his own practice he treats the womb as an infecting, suppurating wound.

Dr. French, of Minneapolis, was so entirely in consonance with the views of the writer that he could not criticize.

Dr. Hull, of Arkansas, did not think the essayist correct in considering the uterus as a subcutaneous wound. He thought the state of affairs quite different.

Dr. M. Gordon, of Portland, Me., said that no man was fit to practice medicine who was not clean. He thought every man better off with a bath a day. Hot water was all that was necessary. You can find reports of as many deaths from carbolic acid and bichloride poisoning as you can from sepsis in the same time.

Dr. R. Beverley Cole, of San Francisco, Cal., spoke against the ideas expressed in the paper in the strongest terms. He defied anyone to show better results in midwifery since the introduction of antisepsis than before.

Dr. Kane, of St. Louis, and Dr. Stone, of Virginia, spoke in favor of antiseptic midwifery.

Dr. A. Reeves Jackson, of Chicago, read a paper on Vaginal Hysterectomy for Cancer. He quoted largely from authorities and tables, and drew the deduction that the mortality was so enormous that the relief gained from the operation was nil, and therefore he thought the operation was unjustifiable and should be abandoned.

As no one present had performed a vaginal hysterectomy for cancer the paper was not discussed.

The Section then adjourned.

Thursday, April 30th—Third Day.—Dr. E. Zink, of Cincinnati, read a paper entitled Emmet's Operation—When shall it and when shall it not be performed?

The Doctor went to great labor to compile a paper which treated of the subject in a most thorough and classic manner. He addressed a letter to twenty-five prominent gynecologists in this country and abroad, asking them twelve questions on the subject.

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The sum of their answers he presented in tabular form. The number of cases reported operated upon was 4,945, and from the answers to the letters addressed to these gynecologists, from study, reading and thought on the subject, together with his own experience, he drew a series of conclusions, numbering in all twelve. No. 4 was, the operation should never be performed, *eo ipso* in cases of simple fissures or lacerations of first or second degree.

DR. HARVEY, of Indiana, opened the discussion. He thought that in many instances the pain was greater in slight tears than in large ones. Large tears eventually cicatrize and do not pain, small tears fissure and become very painful and tender. He likened them to fissure of the anus, and, contrary to Dr. Zink, thought they should be opened and cauterized.

DR. WATSON, of Louisville, said the doctor had omitted to state the fact that it was sometimes necessary to operate immediately.

Every case is an individual one. He thought operation contra-indicated if the case improved under treatment, and contrariwise if sterility or disposition to abortion persisted.

DR. GORDON, of Maine, said that Dr. Emmet stated that he had never seen a case of epithelioma cervicis without laceration. Dr. Gordon thought every laceration should be operated upon, fearing epithelioma.

DR. KING, of St. Louis, confirmed Dr. Harvey's statement concerning small lacerations, which were more liable to develop cancer than the large ones. He thought Dr. Emmet very inconsistent in regard to operating on small lacerations, and regarding the occurrence of epithelioma.

DR. ALDRICH, of Pennsylvania, thought every case should be operated upon. He had seen scratches on the cervix cause much trouble.

DR. HALE, of Illinois, held the conservative doctrine, yet it was not always the little laceration which should be let alone.

DR. HEALY said that trivial lacerations do not skin over as has been affirmed.

DR. LEWIS, of New Orleans, had once thought every laceration should be operated upon. With greater experience he has become more conservative.

DR. H. O. MARCY, of Boston, was glad to hear from gentlemen from all parts of this land that they were able to diagnose cercivical lacerations. Our "masters" across the water are not so expert. He was more conservative now than five years ago.

DR. REID, of Ohio, said it had been claimed by the gentleman that every woman who had had a child had a lacerated cervix. He had seen hundreds of women who had children and no laceration of the cervix.

DR. BATTEY, of Rome, Ga., was not in favor of operating on every case.

DR. SUTTON, of Pittsburg, closed the discussion, Dr. Zink being obliged to go.

DR. GORDON, of Maine, read a paper entitled Reasons For and Results of some Cases of Tait's Operation. He recounted a discussion he heard at Copenhagen, in which Sir Spencer Wells criticised the paper of Koeberle, of Strasburg, saying no woman should have her ovaries removed from symptoms alone, and not unless we could prove disease by

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the touch. He gave the history of seven cases on which he had operated for symptoms alone, and found the disease and relieved the symptoms.

Dr. B. G. Heard, of San Antonio, Texas, read a paper on Intra-Peritoneal Adhesions in Relation to Tait's or Battey's Operation. He thought that in many cases when Battey's operation was performed, it was only necessary to open the abdomen and remove the adhesions.

Dr. Battey, in discussing Dr. Gordon's paper, said many considered the field for his operation a very limited one. Sir Spencer Wells had used it but twice, Dr. Duncan but once.

The discussion was continued by Drs. Sutton, Gordon, Wather, Hedra and Harvey.

Dr. Horatio Bigelow, of Washington, D. C., being absent in Europe, a paper by him entitled Notes on Surgical Gynecology in the Berlin Clinics, was read by Dr. Sutton. The gentleman being absent the paper was not discussed.

Dr. W. A. Jaggard, of Chicago, read a paper entitled The Ring of Bandl. The paper was a very elaborate one, with numerous anatomical photographs. He concluded as follows: "The state of our knowledge is not at present such as to warrant us in a positive decision, but the weight of testimony is in favor of the existence of the Ring of Bandl."

Dr. T. A. Reamy, of Cincinnati, being absent, his paper on "Treatment of the Pedicle," was not read.

The Section then adjourned. H. J. R.

Books.

A Treatise on Amputations of the Extremities and their Complications.—By B. A. Watson, A.M. M.D., Surgeon to the Jersey City Hospital, etc.

As its title implies, this work is a monograph upon the subject of amputations, and including as it does, their complications, which embrace all those conditions complicating wounds of all kinds whether surgical or accidental, it is certainly a treatise covering a very extensive field. The work is one which would have required but little additional labor to convert it into a treatise upon operative surgery. It is encouraging to note that this book is the outcome of years of experience and observation, rather than of surgical teaching, and that it is entirely free from the pedantry which characterizes some of the work of otherwise excellent didactic teachers.

The first chapter is devoted to the history of amputations in general, and it must be admitted that the author has taken infinite pains to ransack ancient history in search of the earliest mention of amputations, and the ancient methods of hæmostosis. The practical worth of this very exhaustive research in ancient surgery is somewhat dubious, but the author has certainly acquitted himself very creditably. In the second chapter we have an excellent dissertation upon those conditions and circumstances which determine or modify the prognosis in amputations, such as age,

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habits, hygienic environment, functional derangements and organic diseases. The value of this chapter can hardly be overestimated, for I believe that we are many of us prone to be neglectful of these very important points. It is attention to these details that makes the surgeon, particularly if it be combined with a sound knowledge of pathological processes. The brilliant operator is too often a hewer and carver of human tissues, rather than a surgeon in the true sense of the term. The popular verdict is too often favorable to him whose operations are characterized by the greatest eclat, rather than deliberate judgment. We think that rather too much stress is laid upon "arterio-capillary fibrosis," as taught by Gull and Sutton, and are as yet unprepared to believe that alcohol, by virtue of this "fibroid" change of tissue, is a more powerful pathogenic factor in the moderate drinker, than in the confirmed inebriate. We regret to note that Dr. Watson is inclined to agree with Paget, in the assertion that "the administration of chloroform is not especially dangerous in any such patients with diseased hearts as any reasonable man would think of operating upon." This proposition of Pagets', looks logical enough, but unfortunately, it is not every "reasonable" surgeon who is a good diagnostician of cardiac affections, and more than this, Fothergill, Brunton and others have shown that the physical signs of certain cases of cardiac disease which are imminently dangerous to life, are often very slight. In a general way it may be said that the prominence of a cardiac murmur is not an accurate criterion of the amount of damage which the heart has actually sustained, consequently the rule should be a cardinal one, to refuse to administer chloroform to a patient with cardiac disease, however slight, excepting the patient or his friends be willing to assume the risk which the conscientious surgeon will thoroughly set forth. The comparative dangers of shock from operation, and chloroform narcosis will of course be taken into consideration. What has been said of chloroform will also apply, but with less force, to ether. That the use of chloroform in lieu of ether, is reprehensible, other things being equal, goes without the saying. Dr. Watson has given us the indications for amputation in a very few words. In Chapter III we find enumerated the following objects to be attained by amputation:

1. The preservation or prolongation of life.
2. Restoration to that condition which will enable the patient most readily to procure a livelihood.
3. The removal of unsightly deformities, the relief of pain or the accomplishment of some other equally necessary purpose, which cannot be afforded by a less dangerous and more desirable operation.

The question of operation in cases of bearable deformities is expatiated upon quite thoroughly, and our author is inclined to look upon such amputations as warrantable. For our own part, we are inclined to think that such operations should be performed with great circumspection, if at all. It is well to remember that every fatal result following an amputation, tends to lessen popular confidence in surgery in general, and the fact of the amputation having been in a certain sense unnecessary, would not fail to still further depreciate that confidence. If a man wishes to have a deformed limb removed, no one can question his right to submit to an

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operation, but the surgeon has an equal right upon conscientious grounds, to refuse to operate. The different methods of amputation, the instruments necessary, the subsequent dressing of the wound, etc., are thoroughly discussed by Dr. Watson, and in a way that demonstrates his extensive experience most conclusively. A chapter upon artificial limbs will be found to be an interesting as well as valuable feature of the work, and one which might well supplement some of our more pretentious works upon general surgery. The surgeon's duty does not terminate with the cicatrization of the amputation stump, for neglect and ignorance in the matter of subsequent management, may seriously impair an otherwise excellent result.

An excellent chapter upon the complications of wounds, terminates the volume, which for thoroughness of detail, is beyond criticism. We are rather struck with the arbitrary manner in which the phases of disease termed "septicæmia" and "pyæmia" are treated. We believe that the doctor is in error when he states his belief that "the intelligent surgeon has little difficulty in differentiating septicæmia, pyæmia and septo-pyæmia." If septic poison, like malaria, gave special forms of morbid symptoms, we would have little difficulty in differentiating the various phases of septæmia, and might classify them quite as clearly as are the forms of paludal fever, under the heads of quotidian, tertian, quartan, etc. The mere fact that the author has claimed a septo-pyæmia, shows that he, whether consciously or not, is influenced by those evidences of interdependence of the three phases of disease, which others believe to establish their identity. "Septicæmia," "ryæmia" and "septo-pyæmia," are simply different manifestations of the same morbid condition, and their differences depend upon: 1. The hygienic condition of the patient. 2. The condition of the wound. 3. His power of resisting infection. 4. The plasticity of the blood. 5. The intensity, amount, and duration of infection, and last but not least, 6, the condition of those organs whose function it is to eliminate morbid materials from the body. To these phases of disease, taken collectively, the term "septæmia," or "toxæmia," might be applied. When we are informed, that the "cause of pyæmia is pus, or one of its constituents," we wonder if the old is to be made new, and our bacteriologists thus summarily squelched. Having defined our position in regard to some of the points * involved in Dr. Watson's treatise, we have no hesitancy in saying that a more comprehensive presentation of the subjects of which it treats, would be difficult to find. That we believe it valuable, is evidenced by the fact that we have read, rather than reviewed it. In the illustrations and general make up of the work, we can only say that it is up to the usual standard of the publishers, and consequently, as good as the best. G. F. L.

THE MICROTOMIST'S VADE-MECUM:—By Arthur Bolles Lee. 12 mo. pp. 424. Philadelphia: P. Blakiston, Son & Co., 1885.

Seldom is it that as useful a contribution finds its way to the work-table of the histologist as is the volume before us. Many a sigh, we ween, will accompany the thoughts of all the labor expended on those tenderly fostered individual "note-books" of methods and formulæ, representing the

* Vide p. 581.

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industrious collection of years, whose suggestions, as well as contradictions, ever furnished a theme for experiment.

To find in one's hand a book dispelling the necessity of all this care is, at once both disappointment and satisfaction, b ut the pleasure greatly preponderates.

In preparing the *vade-mecum* the author has placed within the appropriation of every worker an exhaustive review of almost *all* the many methods relating to every stage of histological work.

While critical scrutiny reveals the absence of some few formulæ, which would be worthy additions, yet the book is practically encyclopedic.

The especial features which will render it so welcome to American histologists, are the full discussions of the more recent Continental methods, so advantageous for refined investigations. Here he will find all needed directions for the most approved plans of fixing and hardening, embedding and section-cutting, staining and mounting. Of the forty-eight chapters of the book, thirty-two form Part I.—devoted to a complete description of all the methods of recognized worth. In Part II., discussing the methods best adapted to special lines of research, the study of cellular structure, embryology, nervous structures of special sense, as well as the general elementary tissues, receive generous attention, to which are added chapters devoted to the study of invertebrate forms.

The inevitable tendency towards confusion and indecision when the tyro is confronted with such an array of methods from which to choose, is greatly countergcted by the judiciously expressed general considerations, which introdeae the several chapters—those preceding the stainings are well worth careful note—whose study can scarcely fail to indicate, at least, a conservative plan of procedure.

Space forbids notinpl in detail any of the valuable suggestions and hints found upon almost every page, suffice it to say, that the *Microtomist's Vade-Mecum* is a book *without* which no advanced histologist can afford to be, and one to which the beginner will do to turn for reliable instructions in all pertaining to modern histological methods. G. A. P.

THE OLEATES; An Investigation into Their Nature and Action.—By John V. Shoemaker, A.M., M.D.

In a neat little book the author presents the subject of oleates, in a clear, concise and practical manner, which bears the information required without loss of time spent in superfluous reading.

A MANUAL OF DERMATOLOGY.—By A. R. Robinson, M.B., L.R.C.P. & S., Edin., Professor of Dermatology at the New York Polyclinic; Professor of Histology and Pathological Anatomy at the Woman's Medical College of the New York Infirmary; Member American Dermatological Association, etc. Bermingham & Co., Publishers.

This work, while only intended as a manual on the subject, and an introduction to a much larger and more complete work, which the author intenda to have ready for publication in the near future, is in itself quite comprehensive, containing over six hundred pages, and contains many

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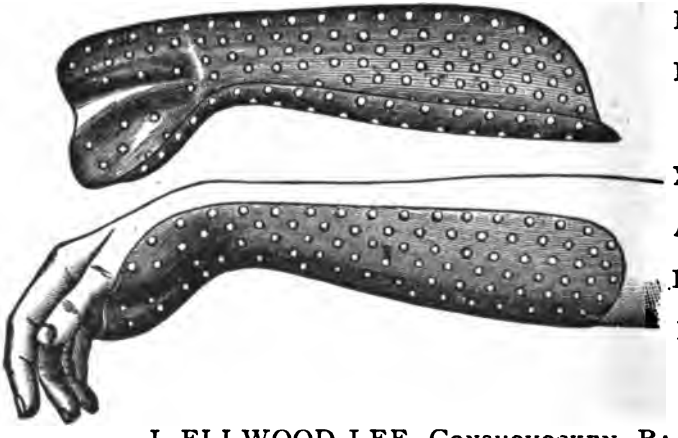
new illustrations which are the result of the personal histological investigations of the author. Judging from the "Manual," we predict for the complete treatise something well worthy of publication. H. J. R.

Miscellaneous.

—It is an established fact that the most natural, the most perfect substitute for mother's milk, is milk again, particularly cow's milk, properly diluted and sweetened with sugar of milk. Cow's milk in its ordinary state, however, is not properly reliable and digestible for either infants or invalids. But by the new process employed in the preparation of Dyer's Special Cream Brand, the milk is converted into the most digestible and nourishing of foods. In fact, in digestion it undergoes precisely the same changes as mother's milk; does not curd like fresh cow's milk, and cannot cause flatulency. This preparation keeps for years in any climate, yet contains no cane sugar or other addition.

The Monon Route (L., N.A. & C. R'y.).—Commencing Sunday, June 7, this line adopts a new time card. It puts on additional local trains, and by higher speed and few stops its through trains now make faster time than any other road, between Cincinnati, Louisville and the south, and Chicago and the summer resorts of the north. It is the only line running Pullman palace cars and through solid trains between Chicago and Louisville. Pullman sleepers and through trains between Chicago, Indianapolis and Cincinnati. To the business man or the tourist, the Monon Route offers superior inducements in quickest time, best accommodations and lowest rates.

LEVIS'S METALLIC SPLINTS.



No. 1.—Right and Left. For Fracture of Lower End of the Radius. Made in Two Sizes, Adult's and Children's. Price $1.00 for each piece. Manufactured according to Dr. Levis's directions by

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THE WESTERN

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Medicine.

Edited by WM. E. QUINE, M.D., 3151 Wabash Ave.

The Cholera Epidemic in Spain is assuming large proportions. Towns are depopulated by pestilence and panic. From June 6th to the 18th, official reports show 2,858 cases, and 1,273 deaths. At the present time from 700 to 800 new cases are reported daily. Nearly half of those attacked die. The malady is most destructive to the poorest classes. The efforts of the sanitary officers to protect them are often resisted by mobs of ignorant fanatics, who consider any measures of prevention, except prayer (*sic.*), as sacreligious.

Koch's theory of the causation of cholera is, perhaps, further from general acceptance than ever. It has recently been characterized by an eminent English writer, Dr. Burden Sanderson, as "an unfortunate fiasco." The present status of the question is as follows:

The existence of comma-bacilli in choleraic discharges is admitted by authoritative writers. Koch claims that of persons who have died in the acute stage of the malady, the lower part of the ileum contains almost a pure cultivation of the bacilli. Klein denies this. He admits that the bacilli are present in the mucus flakes of choleraic stools, but he insists that the sooner after death examination of the contents of the bowels is made, the fewer the number of bacilli that can be found, and these are invariably accompanied by other microbes.

Koch claims that the mucous lining of the ileum shows loosening and detachment of the epithelium,—the solitary glands and Peyer's

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patches being prominently affected in this way. He ascribes these changes to the presence of comma-bacilli, and to the absorption of a peculiar ferment. Klein maintains that in as much as no comma-bacilli, or bacilli of any kind, can be found in the loosened epithelium *immediately* after death, there is no proof that the disease is caused by them, or by their poisonous secretions. Both writers agree that the blood and other tissues are not infested with these organisms.

Koch claims that the bacilli are of diagnostic value. Klein asserts that he has found them in intestinal discharges, not choleraic, and in the mouths of healthy persons. Deneke claims to have discovered them in stale cheese.

Koch asserts that cholera can be produced in lower animals by injecting bacilli into their small intestines. Klein denies, and he is supported by certain German scientists who have partaken of raw microbes,—colonies and nations of them,—for dinner, without detriment to health. On the other hand Dr. Watson Cheyne, one of the ablest and most painstaking investigators maintains the accuracy of Koch's results. It will be seen from these contradictory statements that the question is yet to be decided.

Inoculation Against Cholera.—The daily papers inform us that Dr. Ferran has inoculated nearly 5,000 persons with cholera microbes as a preventive of cholera, in the province of Vallencia. His work has been extravagantly eulogized.

Epilepsy.—M. Wildermuth (*Lancet* Aug. 2nd, 1884), has employed osmiate of potassium, with advantage in the treatment of epilepsy. The maximum daily dose employed was $\frac{1}{4}$ of a grain. Every case under treatment was more or less benefited, but in only one instant was complete immunity conferred.

Epilepsy.—Dr. Brown-Sequard, speaking at a late meeting of the *Societe de Biologie*, said that there existed a manifest inhibition in certain phenomena in epilepsy from the beginning of the attack. In some cases there was a complete abolition of reflex movements; in others the reverse takes place, and the reflex faculty is so much exaggerated that if one touches the paralyzed member it is sufficient to produce an attack, or to increase it if it has already taken place. A motion of the part is often quite enough to start them off; even a simple draught of air on the part has been known to have the same effect. In both cases, when the reflex faculty is lost, and those in which it is increased, it is the spinal cord that is affected; but he would

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not say that the cord was the only seat or origin of the trouble, but that the cord is always influenced by the brain. It is true that in certain animals when we produce a lesion of the cord in the cervical region, we produce an attack of epilepsy; but that does not prove, even in the animals experimented upon, that the cord is the exclusive seat of the disease; for a lesion of the pons Varolii will also produce an attack. There is one difference in these two cases: when the lesion is in the cord the epileptic zone is in the corresponding side, whereas it is on the opposite side when the lesion is in the pons; but, wherever the seat of the epilepsy may be, the cord is always influenced.

He also detailed another interesting experiment in a dog which had a traumatic lesion of the cerebellum. He had observed spinal epilepsy, in which traction, or malaxation, or galvanization of certain muscles,—any peripheric excitation,—would provoke an attack. This case of spinal epilepsy following a lesion of the cerebellum is, he thought, the only one known. We know that there exist in man, following lesions in the brain, zones which, when excited, give rise to convulsive attacks, or exaggerate such attacks when they already exist. All these facts demonstrate that the nervous centres can determine an inhibition or an exaggeration of the functions of the cord. Prof. Brown-Sequard called attention to the practical point to be derived from these facts, which was the importance of finding the peripheral points which can be excited in epileptics, and to direct the treatment there by counter-irritation with the thermo-cautery or other revulsives.—*Phil. Med. Times.*

Morphio-Mania—Prof. Grasset, of Montpellier, recently delivered a lecture on the "Treatment of Morphio-Mania," in which he said that some authors prefer to break off and suppress the remedy at once, but to do so exposes these patients to collapse that may be dangerous, just as in cases of alcoholism, where the complete suppression of liquor will often lead to attacks of delirium tremens. This rule, however, is not absolute, nor general in its application; for instance, in the case of tobacco, it is best to break off at once and not practice dimunition day by day. But with morphia it is better to go slowly and reduce the dose a few milligrammes daily. If, as often happens, the morphiomaniac is used to his four, six, or more injections daily, it is best to continue them, but reduce the amount each time, rather than to reduce the number of the injections. The question arises here, ought we to do this with the consent of the patient or without

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it? Here he would at once say that it is not possible to cure them against their wish. They must desire it, and strongly, too, if we hope for a cure. However, if possible, it is well to make the diminution more than the patient thinks it is. This must be done also in a regulated way. To obtain success, it is indispensable that the doctor have complete control of the administration of the drug. He must make the solution of morphine and himself give the injections. In order to make sure that all the care of the physician does not come to naught, there must be a secret watch kept over the patient so that he will not procure morphine and inject it himself. Some of them have been known to forge the handwriting of a doctor to a prescription.

Great care must be taken to find out the reason why the patient originally took to morphine, so that the proper treatment may be directed to suppress the cause as well as the baneful drug. This will also lead to a judgment as to which one of the injections it would be well to suppress first. For instance, persons who suffer from gastralgia, continue the one just before a meal up to the last. In others who got the bad habit from the injection given for insomnia, keep up the evening dose It is also a good plan to retain the morning dose up to toward the last.

This much said on the manner of stopping the morphine, what shall take its place while attempting a cure? Alcohol takes one of the first places. Give good wine, even cognac, at the risk of their taking a new bad habit. It is one that can be stopped better than morphine. There are moments during the cure of morphiomania when the patient is in a complete state of prostration, when he will not leave his arm-chair for days at a time. Then use alcohol, and for the same indication give coffee, caffeine, acetate of ammonia, even injections of ether, though their effects are but temporary. Ether is especially useful if there is any danger of collapse.

For sedatives, the bromides may be employed in the presence of hysteria or any general nervous symptom. For insomnia, chloral acts well. Cocaine also has been tried lately; it may be used whenever there is pain in any part of the mucous membranes. For instance, coacine is certainly indicated by its analgesic properties over the mucous lining of the stomach in all cases of painful dyspepsias. But what cocaine does for the stomach is only what it can do for all the accessible mucous linings, such as vaginal, urethral, etc Its use for the eye is already classic. In fact, what opium does for the inte-

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rior, cocaine does for the exterior mucous membranes. Water in all its forms is a powerful aid in the treatment of our morphia-ridden patients, used as douches. Lotions with cold water are not only stimulants but real tonics to the nervous system,--that is to say, water will combat not only the actual depression, but it will go farther and act on the nervous system, and will even effect a radical cure, as it does in real hysteria, where hydropathy is the principal, often the only, treatment. On the other hand, warm baths sometimes act well in these patients when kept up a long time. He recommended also prolonged baths of static electricy. The public have retained the old idea that electrical treatment was one of shocks and efforts to contract the muscles, but the practitioner of these days knows how to use it as a means of sedation as well. Prof. Grasset closed by recommending that the doctor should never place in the hands of patients the hypodermic syringe, and, when giving a prescription for morphine, to add on it the number of times that the druggist should fill it, so as to prevent the rapid formation of the morphia habit.—*Phil. Med. Times.*

Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

A New Treatment for Incontinence of Urine by Dilatation of the Bladder. —A youth of 12 years of age, robust and well developed every way, presented himself to Dr. Margarit, for the treatment of incontinence of urine of long standing, which had resisted the classical medication in the hands of various able practitioners. After going over the same ground as his predecessors, with like results, the author concluded to tread an inverse road, based upon the following reasoning: It is a law in the system that all cavities and channels destined to contain a product of whichever nature, if perchance they fail in this purpose, their capacity is diminished, through hypertrophy of their parietes. It occurs in the rectum, in atonia of the sphincter, in the stomach, through inability of the pylorus to retain the alimentary pulp, and finally, in the lachrimal and Stenon's ducts, when the tears and the saliva are, through a fistula, deviated from their normal routes. By vesical catheterism, this theory was verified, as the urethra and the bladder were found, the first, so narrow as to, scarcely, admit a filiform bougie, and the second, unable to contain more than 3vi to 3viii

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of liquid. After the urethra was sufficiently dilated to admit the passage of an 8 or 9-millimetre sound, the bladder was also dilated by tepid water injections, once a day, retained the longest possible and increased, by degrees, until the amount of 150 or 200 gram. was reached, which proved to be the utmost tolerance of the organ without severe pain. At this time, the urine could be retained from three to four hours, whilst before this treatment micturition occurred every hour or hour and a half. The treatment lasted thirty days, one injection a day.

In resume, the medicaments used in this affection, in alphabetic order, are as follows: Aromatic baths, benzoic acid, belladonna blisters, cupping, cauteries, cantharides, creasote, cold douches, chlorate, electricity, glycerine, gelsemium, iron, mastich, nux vomica, nitrate of silver (prostatic cauterization), quinine, strychnine (hypodermically), tannin, and zinc (bromide).

An article from Desorneaux' pen, in the *Diccionaire de Medicine*, by Jaccoule, upon incontinence of urine, mentions the following, which favors my theory: Trousseau advised to retain the urine, the longest possible, to diminish the vesical muscular ton by distention of the viscus.

Salicylic Acid in Urticaria.—Lassar (*Monatschefte f. Prakt. Dermatologie*) reports the case of a man, who had for six years been subject, at various intervals, to the most severe attacks of general urticaria, involving even the mucous membranes, and accompanied by general malaise and febrile disturbance where the salicylate of sodium treatment was followed by very beneficial results. The patient was apparently otherwise healthy, and no cause could be assigned for the trouble. The drug was administered in twenty-four grain doses at the onset of each attack, and repeated every two hours until two more doses were taken. The attacks were thus cut short and much reduced in frequency.

A Fatal Case Resulting From the Administration of Antipyrine.—We translate the following from the *Journal de Medicine* of May 31st:—A woman thirty-five years of age, miscarries at five months,—Dec. 4th; keeps her bed until Jan. 15th, when she is sent to the hospital with the diagnosis of enteric fever. She is feeble, but not, proportionally emaciated; accuses no acute pains anywheres; pulse regular, but small and depressible; cardiac and pulmonary sounds normal; tongue moist and slightly coated; a little tender to pressure over the abdomen, but not limited to the ileo-coecal region. Temperature 39° C.

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The duration of the disease (six weeks), the history of the case (miscarriage), the absence of positive signs of *enteric fever*, lead us to believe, that probably we had to deal with a *puerperal affection.*

January 16th, pulse 120; temperature 39.5° C. No new symptoms apparent. Prescribed, quin. sulph., ninety centig., to be taken in three doses in the day. Jan. 17th, pulse 132, temperature 39.8° C., bowels free. The quinine is discontinued and, to reduce the temperature, a dose of antipyrine (two gram.) is given at 3 P.M., and another of one gram., three hours after, with the object of prolonging the effects of the first. At 6 P.M., pulse 108, temperature 37°, skin cool and moist. At 11, the temperature continues the same, but the pulse has raised to 132. On the 18th, in morning, notwithstanding a restless night, the temperature is 36.8°, and the pulse 120. The patient suffers no pain, but is very weak. Fifteen gram. doses of brandy are given every two hours; no reaction. The symptoms of collapse become more conspicious in spite of the stimulants, and the patient succumbed at 11 P.M., thirty-two hours after the initial dose of antipyrine. Temperature an hour before death was 38° C.

The post-mortem revealed no well defined lesion; intense congestion of the brain and its envelopes with some hemorrhage; heart, somewhat soft, but no valvular lesions; lungs much congested; liver normal; spleen much enlarged (1350 gram.), with a great infarctus in the centre; kidneys infarcted, and somewhat large; bowels normal and uterus contracted and empty. Death appears to have ocurred through the collapse which followed the lowering of temperature by antipyrine, and not by the effects of the disease.

The Prophylactic Inoculations with Micro-Organism of the Cholera. — From the *Gaceta Medica Catalana*, published in Spain, we translate the following: In proportion as the Asiatic cholera spreads and gains in virulence, so diffuses the enthusiasm for the prophylactic inoculations, and the demands of the people for the fluid which shall liberate them from the epidemic. The impossibility of a prompt response to their solicitations, causes the accumulation of large crowds who, by means of their fists, try, each, to be the first in the process of inoculation; the aid of the police being required to maintain order. In over 12,000 individuals inoculated, the greatest majority have escaped the scourge, and a few who have had it, were affected in a mild form. The town of Alcira for instance, whose population is about 16,000, counts about 7,000 people inoculated and 3,000 re-in-

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oculated, from the 1st to the 20th of May, with the following results: Affected, 73; died, 39; cured, 21; under treatment, 13.

Among the inoculated, only 7 were affected, 5 being cured; the other 2 were inoculated when already a prey to the disease and succumbed; of the re-inoculated only 4 were affected, being all cured. These figures are of the utmost importance; they represent the triumph of the doctrine in the clinical field, as they have done in the laboratory.

Dr. Ferran, of Tolosa, the author of the cholera inoculation, has fully reported his results to the *International Sanitary Conference of Rome* with the date of May 20. He has also availed himself of this same rich experimental field for other studies of the utmost transcendency. Familiar in the handling of the cholera prophylactic fluid, which he uses with safety, the author has obtained, after gradual experiments, cases of experimental cholera in man, in which no symptom was wanting; vomit, profuse diarrhea, algidity, cramps, anuria, etc. Three patients with chronic rheumatism were cured after the disturbances caused by the inoculation. This may be a mere coincidence, but points to new studies to verify it.

Dr. Farran also announces a very interesting fact, of a woman with the cholera in the algid stage. (collapse) whom he inoculated with an attenuation of the fluid which provokes hypertermia, without premonitory chill, which brought the reaction in a short time.

If his experiments should proceed with the same degree of success, it may yet occur that, by choosing cultivations of different strengths, the same agent may become both prophylactic and curative.

Laryngology.

Edited by GEO. F. HAWLEY, M.D., 125 State St.

(*Concluded from p. 212.*)

On Some Complications of Tracheotomy, with Illustrative Cases.—3. *Irritative Changes due to the Presence of a Tube.*—In a few cases the mere presence of a treacheotomy tube in the trachea, even when perfect as regards length, shape and size, appears to give rise to an irritation which is quickly followed by the growth of granulations. A considerable amount of granulations has been found in from four to eight days in cases which have terminated fatally. Such a condition may be suspected if the insertion of the tube appears to cause

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undue irritation, and especially if its insertion is followed by blood-stained secretion. The use of the feather also causes very considerable irritation, and has to be discontinued. In cases where the granulations about the external wound proliferate with unusual exuberance, such a growth may be suspected within. This peculiarity seems to depend upon a hypersensitiveness of the tracheal mucous membrane, and it is an idiosyncrasy which must be taken into account. Minor degrees of this condition are often experienced, some tracheotomised children never reconciling themselves to the cleaning and changing of the tube.

If granulations spring up, the best treatment is the local application of nitrate of silver. A silver probe, after being suitably bent and coated with fused nitrate of silver, is introduced into the tracheal wound, and made to touch as nearly as possible those parts on which the tube has rested. Or a few drops of a thirty-grain solution of nitrate of silver may be allowed to trickle into the trachea, the child sitting upright and inclined slightly backward, so that the solution may run over the affected portion of the trachea.

The granulations I am now alluding to may occur all round the trachea, and not merely on the anterior wall or at one spot; for they are not due to pressure, but, as before stated, to the presence of a foreign body in an unusually sensitive trachea. I have a specimen of a tachea in which granulations due to this cause were very abundant over the whole track of the tube. There was no sign of ulceration; the granulations occurred within five or six days of the operation. The child appeared to be doing very well, until one night it was suddenly choked after a violent fit of coughing. The autopsy revealed the presence of granulations between the tracheal wall and the tube, which doubtless during life were florid and turgid with blood, and completely filled the space; one currant-like granulation, larger than the rest and attached to a small pedicle, had apparently been driven by the coughing into the tube and completely occluded it.

In the case of warty laryngitis—that is, when there is a natural tendency to the formation of warts—the irritation of a tube leads to the production of minute warts, instead of granulations proper below the tracheal opening. In the case of granulations proper, some difficulty is usually met with in the removal of the tube. At first sight the obvious remedy is the removal of the cause; but an acute obstruction having necessitated the use of the tube, granulations having

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occurred and actually existing, the difficulty arises of how best to treat them. Such cases all point to the desideratum of tracheotomy without the use of tubes at all. At present, I have not been able to dispense with them; nor do I know of any trustworthy means of gaining the desired objects without tubes; at the same time it is a desideratum I have constantly in mind, and which I recommend to the consideration of my professional brethren.

As to treatment, reference has just been made to the use of nitrate of silver once a day, or once in two days. The alum spray or tannin spray (an ounce of tannic acid glycerine in seven ounces of water) must be used at frequent intervals through the day and night. The tube should be removed for as long as possible, and the silver plug inserted, the patient being meanwhile under direct supervision; for on the removal of the tube, the granulations swell out, and if present in quantity they in time occlude the trachea. Hence in a few instances a child will breathe well for an hour or two, then the tube must be reinserted. The explanation appears to be as follows: The tube by its presence keeps back the granulations, but having been removed, they commence to swell up; possibly also the more labored breathing (which follows the removal of the tube), by causing congestion, helps them to still further occlude the trachea. Cauterisation astringents are the best remedies, and are generally successful.

4. *Accidental Conditions.*—Under this heading I shall include two cases, which, though not unique instances, are nevertheless so rarely met with as to require separate consideration. They appear so purely accidental in their incidence that none but the most general precautions can be taken to guard against them.

Case 6. *Catarrhal Laryngitis; Tracheotomy; Difficulty in removing Tube; Hypersensitiveness of the Trachea; Death in Convulsion fifteen days after removal of Tube; Autopsy; Large Granuloma at the seat of cicatrised Wound inside the Trachea.*—Eliza M——, aged two years and a half, was admitted into the hospital under the care of my colleague, Dr. Eustace Smith, on February, 1882. She was one of eight children, of whom one had recently been suffering from quinsy. She had enlarged glands about the neck, secondary to eczema capitis, to which disorder she was very subject. She was a plump, well-nourished child, and well-grown for her age, with no very manifest signs of rickets. On admission she was said to have been hoarse for two days; she had that morning complained of having "a pin in her

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throat." She had no discharge from her nose, and there was no illness in the house. Her breathing had become so labored by the following day that tracheotomy had to be performed by Mr. Battams; the high operation was done; chloroform was administered by Mr. Sanderson, one of the resident officers. No membrane was got up or seen. The child did fairly well; efforts to remove the tube, however, were not successful until March 15th, thirty days after the operation. It was remarked at the operation, as well as subsequently, that the child's trachea was remarkably sensitive; she coughed violently whenever it was necessary to clear the tube or attend to the wound, and one of the difficulties which attended the attempts to remove the tube appeared due to this hypersensitiveness of the tracheal mucous membrane. Finally, the tube was removed, and the external wound gradually closed up. The child breathed fairly well in the day-time, but had attacks of urgent dyspnœa, becoming progressively worse during the nights, with some nights of comparative immunity. The voice was not hoarse. On March 31st, forty-six days after the operation, the child died in a convulsion after an attack of dyspnœa rather worse than usual. The trachea was again opened, but too late to save life.

The autopsy revealed the following condition: — "At the site of the old trachea wound is a highly vascular livid red mass of granulation, more or less pedunculated, projecting into and considerably narrowing the trachea at this point. The ary-epiglotric folds are very œdematous."

In this case the laryngo-tracheal mucous membrane was exceedingly sensitive, and doubtless, also somewhat œdematous. Thus breathing was rather more labored than normal after the tracheal tube had been removed. The granuloma doubtless gradually developed and increased in size, and finally, during an unusually severe paroxysm of labored breathing, it became extra turgid, and so completely occluded the cricoid opening (which is the narrowest part of the wind-pipe), and thus killed the child. A fatal termination to a case of tracheotomy from this cause may be regarded as a rare event. Dr. Petel, in his graduation thesis, [1] only collected ten such cases in addition to the one he himself recorded. In three of the cases a second operation was performed with complete success. In one case the child was

1 Des Polypes de la Trachee, survenant apres Cicatrisation de la Tracheotomie. These de Paris, 1879, No. 500.

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tracheotomised three times, and had still to wear the cannula. In another case the polypoid granulation was spontaneously coughed up. In three cases death resulted before help could be given. In two cases the condition, which had not given rise to any symptoms, was only discovered at the autopsy, death having taken place from some other cause. In a minor degree, nevertheless, I am inclined to think that such a condition is not very uncommon. There are no *a priori* grounds why granulations should not spring up on the deep surface of the wound as they do on the superficial. On the latter, granulations, sometimes very exuberant, are the rule. From a study of the published cases it appears that the granulations have most frequently grown from the upper angle of the wound—that is to say, immediately below the cricoid opening, the point where their presence would be most dangerous. The possibility of such an occurrence has even been urged, but I think the grounds very insufficient, as an argument against the high operation. This condition may be suspected—the patient having previously undergone tracheotomy, the tube having been removed, and the wound being more or less cicatrised—if the breathing again becomes gradually and temporarily embarrassed, the voice generally remaining unaffected. At first this embarrassment will be chiefly obvious at night, when the child is asleep; then during the day-time also. It will be paroxysmal, and vary much in intensity; in the latter stages expiration will be as much impeded as inspiration (or more); there will probably be blood-stained expectoration, especially after paroxysmal coughing. It is probable also that the external wound may have exhibited a tendency to exuberant granulations. Given such signs, what is to be done under the circumstances? The surgeon will have to be guided by the intensity of the resulting dyspnœa; if it tends to improve slowly, the use of the alum or tannin spray may be continued; if it tends to become more marked, a second operation will have to be undertaken and an examination of the part, made, with a view to the removal (if present) of the granulations by forceps, caustic or otherwise. In his interesting graduation thesis Dr. Carrie[2] says, p. 63.—"In these circumstances, with difficulty [of breathing], recession, noisy breathing during the night, we must not await a first access of suffocation, which may prove fatal, but at once re-open the trachea."

2 "Contribution a l'Etude des Causes empechant Ablation definitive de la Canule. These de Paris. 1879, No. 13.

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CASE 7. "*Croupy*" *Cough; Urgent Dyspnœa; Tracheotomy; Inability to remove the Cannula; Sudden Death three months later; Autopsy; Web-like Adhesions between the Cords.*—A little boy, eighteen months old, came under observation on account of a "croupy" cough and dyspnœa, which subsequently necessitated tracheotomy. No membrane was got up. At the end of a week attempts to remove the tube were commenced. They were quite successful, and remained so. The child's general condition was good, and he appeared well in all respects except that he could not get on without his tube. One night he was found dead in bed. No sound had been heard by the night nurse, who had just previously looked at him and found him sleeping comfortably. The bed-clothes were quite undisturbed. His eyes were closed, and his features free from any sign of a death-struggle. The autopsy revealed the following condition. The lymphatic glands, tonsils, follicles of the pharynx, and root of the tongue were very much enlarged. On the anterior wall of the œsophagus, opposite the shoulder of the tube, there was an oval diphtheritic patch three-quarters of an inch long, corresponding with a similar condition on the posterior wall of the trachea. Looking into the larynx from above the vocal cords were seen to be much swollen. Looking up the trachea from below there was no visible passage; in fact, immediately above the tube there was a diaphragm of granulating and cicatrising tissue, which had a short, unattached margin opposite the posterior wall of the wind-pipe and nowhere else. This septum would impede inspiration greatly and expiration altogether. There was great ulceration of the mucous membrane opposite the end of the tube.

5. *Ulceration in the Trachea, due to ill-fitting of the Tube.*—This condition is now of much less frequent occurrence than formerly. M. Roger was the first to draw prominent attention to the subject, and to suggest at once the cause and the remedy.[3] As I have no personal cases to relate, I must summarise M. Roger's views and conclusions. He showed that the complication was more liable to occur in some cases and in some epidemics than in others; but from the anterior wall being most affected, and just at the place corresponding to the lower extremity of the tube, he argued that the chief cause of the ulceration was pressure of the tube, "l'action vulnerante de la canule." This condition is most to be feared when the tube has to worn for a longer period than usual, but it has been found as early as thirty-six

3 Archives Generales Medicine, 1859, Vol. II.

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hours after operation. The ulceration may be only superficial, or it may be deep enough to perforate the trachea; and, as cases are recorded in which the innominate artery has been opened, it will be allowed that this complication is a very formidable one. As symptoms of this form of ulceration, M. Roger gives the following: It is to be suspected if the external wound assumes a sloughy condition, and if the breath and expectoration become fetid, the tube will be blackened, either entirely, or in patches, and there may be pain or difficulty in swallowing. Most of these symptoms, however, may occur without the presence of ulceration, as I have seen on many occasions. The difficulty of recognizing the onset of this ulceration, no less than its dangerous nature, render it incumbent on the surgeon to watch his patient closely on the one hand, and on the other to only use such tubes as are comparatively safe and unlikely to press on the trachea.

M. Roger tried different materials—gutta-percha, india-rubber, flexible ivory; but finally discarded them in favor of silver, recognizing that the ulceration depended on the unsuitable shape of the tube, rather than on the fact of its being rigid. "La forme des canules habituellement en usage n'est pas celle qui conviendrait le mieux." After many successful trials M. Roger finally adopted Luer's tube with the movable collar.

While admitting the immense improvement which was thus effected, I am inclined to think that much of the mischief was really due to the quarter-circle shape of the tube itself. With a view to remedy this defect, I suggested some years ago an "angular" tube. An extended use of this tube leads me to think highly of it, and justifies me, I hope in recommending its adoption by others.

I will conclude by recommending surgeons to be well provided with a variety of sizes; slight differences in length of the tube, in depth from the front opening to the "angle," and in calibre, I believe, often turn the balance one way or another. A tracheotomy tube, like a boot, must fit comfortably, or it cannot be worn without injury. In order to make the inner tube pass the angle, its posterior wall has to be cut away; let me advise that as little as possible be removed. It is impossible to give too much attention to the manufacture of the tubes; all roughnesses and sharp edges must be avoided. Finally, I think it would be an improvement if the interior of the inner tube were polished, for it could be more easily cheaned.

Perhaps the day will come when we shall be able to dispense

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with tubes altogether; at present I know of no efficient substitute, though, as I have already said, my thoughts are constantly engaged in this direction.

The points in common in the foregoing, widely different, cases were urgent dyspnœa, necessitating operation, and subsequent difficulty in removing the tube, it will be seen on what a variety of causes the latter point may depend, and how important a correct estimate of its real one becomes. Since writing the above, I have operated for the second time on a little boy, and found a mass of granulation tissues blocking up the cricoid ring. In addition there appeared some cicatricial narrowing in the upper part of the trachea. The boy is still under treatment, and I am rather fearful that he will have to continue to wear his tube, until further growth in the trachea—which goes on very rapidly as adolescence approaches—has taken place.—*R. W. Parker, M.R.C.S., in Lancet.*

[The following extracts are furnished by Dr. W. D. Babcock, Evansville, Ind.]

Glycerinum Aluminis.—Robert William Walker, Surgeon of the East London Hospital, suggests the above, a new preparation of alum: It is made by dissolving one ounce of alum in five ounces of glycerine by means of gentle heat. It is four times stronger than a saturated watery solution. It can be used wherever a powerful astringent is needed, and is compatible with administrations of iron. In chronic pharyngitis of children it is very efficacious. It can be used as a gargle, injection or lotion.—*Brit. Med. Jour.*

New Variety of Chronic Nasal Catarrh.—Dr. Harrison Allen, in the *Med. News*, of Feb. 7, 1885, describes what he terms a new variety of chronic nasal catarrh. The nasal appearances are given as follows: "The membranes, especially those at the upper portion of the chambers, upon the gentlest manipulation are apt to bleed slightly, the nostrils are not infrequently excoriated, especially in winter. The discharge is mucoid in character. During the height of an attack which the patient is apt to call 'a fresh cold,' it becomes purulent. The discharge passes into the throat as readily as from the throat. In examining a case of catarrh of this variety, which has never been subjected to local treatment, the under surface of the narrow middle turbinated bone is often found covered with a thin layer of fibrinous exudation. A firm pressure against the ledge-like surface will cause the spot which is pressed upon to become instantly of a bright red color. This is a characteristic sign. Pharynx capacious; uvula small; mucous

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membrane pale; tonsils always small; posterior part of hard palate invariably marked by sessil exostosis. Subjects have light hair and fair skin. The exceedingly sensitive character of the nasal mucous membrane, and its disposition to slight bleeding from trifling causes, the absence of the erectile tissue, or its rudimental character when present, a nearly straight septum, hence the absence of nasal obstruction, form a group of characters which may be easily recognized." Prognosis unfavorable. Oleo-resin cubebs painted on membrane seemed to give the best results.

Chronic Catarrh Treatment.—In a short note in the *Therapeutic Gazette*, Prof. D. Hayes Agnew speaks very favorably of the use of sage tea douches in chronic catarrh. One case that had resisted the usual remedies yielded quickly to this remedy.

Nose Bleeding.—From the *Med. Press* we learn that Dr. Henry Perdue, of Barnesville, Ga., uses plugs of fat bacon to stop bleeding at the nose. He secures them by strings and strips of adhesive plaster. This method succeeded after the ordinary plugging and other methods had been tried.

Obstetrics and Gynecology.

Edited by E. P. MURDOCK, M.D., 179 South Sangamon St.

Bromide of Ethyl as an Anæsthetic in Labor.—Dr. E. E. Montgomery, of Philahelphia, Pa., makes an earnest plea in the last number of the *Amer. Jour. of Obstet.* for the use of bromide of ethyl in labor.

There is no question as to the value of anæsthetics in operative obstetric procedures, but their habitual use in natural labor is not yet settled, and there is no doubt, in any physician's mind who has ever given the subject a moment's thought, that there is a great deal of actual pain, and even agony suffered by women in labor. The pains are not simply efforts resemblimg those of defecation—they are more. The stretching and pressure on the soft tissues causes pain of the most severe character; "mere pain can destroy life."

Meigs says: What do you call the pain of parturition? There is no name for it but agony.

Fagge and Curtin report cases in which death occurred as a result of the administration of chloroform in labor. It is not absolutely safe for the mother.

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Ether is objectionable, although safer. The patient must be profoundly etherized to afford relief. Moral control is lost, and the patient cannot render any assistance. Vomiting occurs, and an extra assistant is needed. There is also danger to the child, as ether passes quickly into the fœtal circulation.

The ideal obstetric anæsthetic is one which requires little attention, rapid in action, safe and sure, and it may be added, one which does not destroy intelligence—reducing the parturient process to the ease and painlessness of an evacuation of the bowels. The bromide of ethyl answers these demands. It is a colorless, not unpleasant-smelling fluid, is better borne than chloroform and more rapid in action. It is eliminated through the lungs.

Lebert first employed it in obstetrics in 1882. He published four cases, a forceps operation, a version, and two normal labors, in which he produced complete absence of pain without disturbance of the sensorium.

C. Wiederman in 1883, reported a series of seven well controlled normal labors; and Hœckermann has tried the drug in fifty cases. They pronounced it the long-sought-for, and yearned-after means for abrogation of the curse resting upon mankind, "with pain shalt thou bring forth thy children."

Prof. Muller employed it in twenty-two cases. In nine cases a trifling acceleration of the heart and lung activity was observed. In eight cases dilatation of the pupil swiftly occurred, and very frequently the face became red, indicating that there is no anæmia of the brain, as there is in the action of chloroform. In five cases, weakness of labor was induced, but no hemorrhage followed—or other complication. During convalescence he found a tendency to respiratory disturbances. One patient to whom ʒii were given, complained afterward of suffocation and headache, and a dry cough—coarse crepitant rales were heard over both lungs. These unpleasant symptoms had vanished by the tenth day. Another case had some fever on the third or fourth day of convalescence, and the lungs were filled with coarse and fine rales. These symptoms vanished with profuse expectoration and recovered at the end of two weeks.

The author has used the drug in twenty-nine cases, and regards it a necessity in the practice of obstetrics.

In one case, a woman of delicate physique, who was said to have phthisis in a previous pregnancy, after inhalation of about one drachm

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of the ethyl during three pains, began to complain of suffocation; respirations were slow and sighing, and pupils dilated. The anæsthetic was discontinued, and labor completed normally, but the sensation did not disappear till the next day. To another case ʒvi were administered between 9-30 P.M., and 2 A.M.—forceps—uterus contracted well. About 5-30 P.M., temperature 103°, pulse 152, respirations frequent, abdomen tympanitic, and unconscious evacuations. Almost all these symptoms disappeared the next day.

In another case there was uterine inertia, and the anæsthetic was given for the application of forceps. Shortly after delivery, continued hemorrhage and absence of the uterus led to a vaginal examination, which revealed complete inversion of the uterus. The ethyl was given and the uterus restored to its position. She made a rapid recovery.

The fœtal mortality was three, all due to other causes than the ethyl.

Thus far there have been 112 cases reported in which the drug was used without a fatality.

The ethyl is administered at the beginning of each pain, by use of a napkin on which a few drops have been poured. There is no stage of excitement and no suffocation, but the pain is blunted, while the patient is conscious and able to render or withhold voluntary efforts.

That perpared by Wolf & Co., or Parke, Davis & Co., are recommended as having a pleasant odor and reliable in action. A preparation which has an unpleasant irritating odor is not reliable. W. W.

Pruritus Pudendi, due to Vascular Tumor of the Urethra.—Dr. H. Marshall Fennick reports an interesting case of this trouble, in the *Australasian Medical Gazette*, with remarks upon the subject worthy of note, in which he calls attention to the importance of early recognizing the cause of the difficulty of which the patient complains, and removing the cause instead of treating the symptoms.

Mrs. W——, aged 42, consulted him in Feb., 1884, complaining of an intolerable itching and burning in the "fore-parts," which had troubled her two years. The itching had originally been confined to the vulva, but now extended back to the anus, down the thighs and across the groins, came in paroxysms, lasting from a few minutes to several hours. Patient had lost flesh, was unable to sleep, depressed in spirits, and was irritable in temper until her friends feared insanity. She had undergone all manner of treatment, with no relief.

In searching for a cause he found a small sessile vascular growth, about the size of a hazel-nut surrounding the lower segment of the

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meatus urinarius and extending a distance along the floor of the urethra. The tumor was exceedingly tender and sensitive to touch and bled freely upon the slightest manipulation. There was a free ichorous discharge from the excrescence, and there could be little doubt that this acrid matter mingled with urine was the cause of the pruritis.

The patient was anæsthetised and the carunculæ carefully dissected away, after dilating the urethra so as to reach its uppermost margin, and cauterizing the base with Paquelin's cautery. After-treatment suitable for such a condition was carefully followed and the relief was complete. This report furnishes a good index for a class which can be seen in daily practice, where persistent pruritis resulting from hypertrophic or neoplastic growths in the pelvis have baffled the attendant, who used local washes and failed to recognize the real cause for years, or failed to realize that itching is the infinitesimal expression of pain, and often due to neurotic disturbances having their source away from the seat of the pain.

Surgery.

Edited by G. FRANK LYDSTON, M.D., 123 State St.

The Virulency of the Human Bite.—Casualties resulting from accidental or intentional injuries to the tissues, due to the bite of the human subject, are of much greater frequency than is generally supposed, and we have long held the opinion that the subject has not received at the hands of surgical authorities and teachers, the attention which its importance would seem to justify. We therefore embrace the opportunity presented by the perusal of several recently reported cases, to make a few remarks apropos of some little personal experience in the observation and treatment of injuries of this character. Among the most striking cases of recent occurrence, are the following:

"A lad of eighteen, employed as a waiter at a public house, was guilty of some misdemeanor, and while his employer was remonstrating with him, the lad, fearing a thrashing, took hold of the right hand of his master and bit him severely on the thumb. The publican dismissed the lad on the spot, had his thumb dressed, and thought no more about the matter, when a few days ago—that is, about two months after the bite—phlegmonous inflammation set in, and the patient was carried off in a few hours, death, according to the medical

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attendant, having been from blood-poisoning. In a recent quarrel between two newspaper editors in Paris, one bit the hand of the other, soon after which lymphangitis set in in the arm of the wounded patient, which was accompanied by symptoms of erysipelas, from which, however, he soon recovered."*

The history of the first case is rather incomplete, and does not detail the condition of the part during the period succeeding the bite, and prior to the supervention of inflammation. This point is a very important one, as the history given in the case would lead one to infer that a period of latency followed the injury, which was followed by a sudden inflammatory explosion, in a manner similar to the stage of quiescence following the bite of a rabid animal, and preceding the development of rabies canina. There is no such property of the poison inoculated by the bite of the human species, and phlegmonous inflammation if it develops at all, will do so in a remarkably short time. Hence in this case one would be inclined to believe that the supervention of plegmonous inflammation was merely a coincidence, and the result of some cause independent of the original injury. The second case could justly be attributed to the injury. A case was recently reported † in which nearly fatal septæmia followed a bite received during a domestic brawl, which quite forcibly illustrates the dangers of such injuries, and in certain instances their peculiar character. A man of thirty-five was bitten upon the distal phalanx of the third finger of the right hand; the wound at first bled freely, but was subsequently cauterized by a physician. The part became swollen and inflamed, and at the time he consulted the reporter of the case, was fully three times its natural size, of a tense glistening appearance, and of a purplish hue. The tissues were traversed by a number of sinuses, from which extended an unhealthy looking secretion. The proximal phalanx was carious. The general condition was bad; fever and swelling during the afternoon, with constantly rapid pulse, anorexia, constipation and sleeplessness being the most prominent symptoms. The finger was finally amputated, but without checking either the septic or the local disturbances. The arm became eventually involved, and the septæmia more pronounced, so that the prognosis became very grave. At the end of nine weeks, however, con-

*London *Lancet*, Oct. 25th, 1884.
†Carpenter, N. Y. *Med. Rec.*, May 2d, 1885.

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valescence was established. The report of the case includes some quite suggestive remarks, to which we will hereafter allude.

A professional man of our acquaintance was bitten by a negress during the extraction of a tooth, the injury resulting, being an apparently trivial affair. cellulitis and sloughing, with marked constitutional prostration afterward occurred, and at one time amputation of the injured member was seriously contemplated. A very striking case resulting from the human bite, was exhibited at the clinic at Bellevue Hospital during our pupilage, by Prof. A. B. Mott. The man had been bitten upon the hand about two weeks before, in a saloon fight; phlegmonous erysipelas at once supervened, and at the time patient was seen, serious sloughing had already occurred, which a few days afterward necessitated amputation of the arm. The operation however, was not successful, as septæmia destroyed the patient's life within a few days. We have been fortunate enough to observe two cases in our own practice, which were quite interesting. The first was a man of thirty, previously healthy and strong, who in an altercation with his brother, was bitten upon the forearm. Acute inflammation accompanied by profound constitutional prostration set in within forty-eight hours, and necessitated his removal to the hospital. On examining him we were struck by the marked asthenia, which characterized the case. The limb from the tips of the fingers to the shoulder, was swollen, brawny, and of a dusky red hue. Sloughing had not yet set in, but bade fair to be very extensive. Free and numerous incisions were at once made, with the result of relieving pain and tension, and free stimulation resorted to. The case for a week, did remarkably well, there being very little suppuration and sloughing, when unfortunately, acute pneumonia developed, and the patient soon succumbed. The second case was not so disastrous, but is of the same character: The patient a young man of twenty, struck a companion in the mouth with his fist, with the result to himself of several lacerations upon his hand and knuckles from his opponent's teeth. Inflammation set in on the second day, and was followed by considerable sloughing and suppuration of the back of the hand and forearm. Recovery followed however, in a few weeks.

Now, we think that we are justified in saying that there is an element of disaster in injuries inflicted by the human teeth, which the nature of the lesion does not in itself explain. Were it not so, there would be no valid reason for the non-occurrence of such serious

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results after the majority of lacerated wounds. It will be noticed, that in the absence of specific poison, the gravity of a lacerated or contused wound in a perfectly healthy person, is in direct proportion to the severity of the injury. This, however, cannot be said of the human bite. Popular notions are sometimes clinical facts, and it is a common observation among the laity, that the bite of a man is worse than that of a dog, if the animal be not rabid. It will be observed that we take a view of the matter quite contrary to that expressed by the *Lancet* recently.

In commenting on a case of alleged death from the bite of an epileptic, the *Lancet* says: "There is no poison in the bite of a person in a fit, as there is in the bite of a rabid dog. It is, of course, desirable that every care should be taken to avoid the bite of an epiletic, as it is also that of any other excited or enraged creature; but there is not the slightest ground for supposing that worse consequences will follow an injury of this class than one of any other description, if it be equally severe and is attended on the part of the victim by a morbid state of the constitution."

We will qualify our position by stating that we are not prepared to say that a specific virus is present in such instances, but that there is a special irritant and toxic property in the inoculated secretion, we do claim, and certainly such an assumption is borne out by the results of this class of injuries. In these days of bacteria, microzymes, etc., it is almost hazardous to even suggest the possibility of the existence of any organic poison as a factor in disease, independent of micro-organisms, but in this instance we will assume the risk.

Assuming that a morbid poison does exist in these cases, there will at once arise the question, "where?" The experiments of Pasteur and later, of Sternberg, have conclusively shown that under certain circumstances, the human saliva is extremely poisonous. Claxton * has confirmed the experiments of the gentlemen mentioned, upon rabbits and has found that when normal human saliva is injected into these animals, death results in from one to twenty-one days. In animals of larger size, local results in the shape of phlegmon and sloughing resulted. It would seem then, that the virulency of the results of inoculation with normal saliva, is in direct proportion to the size of the animal inoculated. It is not probable that the normal secre-

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tion would have a deleterious effect upon the human subject, even though dangerous to the lower animals. It is a matter of common observation, that when an animal laps a wound the effect is favorable. Whether the saliva is innocuous to all animals, or only the species of animal which produces it, has not however, been shown. There is one method by which even normal saliva could produce serious results, which is a decided source of fallacy in the recorded experiments, viz.; by simple decomposition of the injected saliva, and consequent simple, septic absorption. This might result from inoculation with any decomposable secretion. As far as we are personally concerned, we would be inclined to regard the results as produced in this way.

There is constantly present in the mouths of everyone—unsavory though the fact may be—a condition of affairs, which is very likely to impart morbid propensities to the saliva: viz.; decomposing particles of food in and about the teeth. It is doubtful whether it be possible to keep the mouth entirely free from these products. In uncleanly persons—and the quasi cannibals who indulge their vicious propensities by biting their antagonists are not usually very near godliness—we can readily understand how this matter is one of great importance. Superadd to this condition, the secretion of carious teeth, an ulcer, and bad tobacco, and we have a poison that would put the witches' cauldron to the blush.

In the presence of these factors, it is evident that our assumption of the existence of some morbid property independent of these things, is necessarilly hypothetical, for our clinical observations might be explained from the stand-point of simple sepsis. Now, the only way in which we could explain the morbid results of the human bite independently of sepsis, and of the part which Sternberg claims a special micrococcus plays in the pathological drama, would be by the presence of an organic alkaloid developed under the influence of the emotions. It has been shown by Richardson, that under the influence of various causes, the body may become self-impoisoned, and that even nervous disorders of obscure origin, may be due to some chemical change in the tissues and secretions of the body, which gives rise to a profoundly toxic product. It is well known that the emotions of joy, fear, and anger, have a most powerful effect upon the physiological secretions. Very few persons, indeed, but have at some time or other experienced the effects of emotional disturbances upon the stomach, bowels or kidneys, one or all. These perversions are probably not of quantity

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alone, but also of quality, and it is our humble opinion that experimentation in this particular field will one day develop most startling results, and demonstrate the great importance of auto-genesis in the production of disease. How frequently we are confronted with a practical confirmation of this statement, in the case of nursing infants who have become seriously ill, as a consequence of some powerful mental emotion in the mother having rendered the milk poisonous. What is true of the lacteal secretion may logically be assumed to be true of the salivary, gastric and other secretions.

The diarrhœa which results from fright, or anger, is perhaps, not due entirely to vaso-motor influences, but in great measure, to perversion of the gastro-intestinal secretions, to the extent that they have become poisonous, and consequently irritating. It is said by natives of India, that the bite of the cobra is not necessarly fatal if the reptile be not angered, but when enraged, no power can save the stricken individual. Perhaps this may be due to a difference in the amount of poison expelled, but it has been shown that within certain limits, the quantity of the virus is not of essential importance. Thus we are compelled to believe that anger does modify the venom. We are inclined to believe that the saliva of an enraged healthy person is of greater virulence than that of an epileptic during the fit, by reason of the presence of emotional influences in the one, and their absence in the other, but nevertheless we think that there must be some foundation for the popular belief in the virulency of the bite of epileptics. The violent disturbance to which the nervous system is subjected during the epileptic paroxysm, must necessarily have an influence upon the physiological secretions. That Dr. Sternberg's view that the morbid results of inoculation with saliva are due to micrococci, we doubt, and while in different cases there may have been an apparent period of incubation, experiment seems to show that there is nothing definite about it, for the symptoms appear from one to twenty-one days after inoculation. The possibility of the phenomena depending upon micrococci must, however, be remembered.

In conclusion, we think that we are justified in stating: 1st. That the human bite is possessed of an element of danger, greatly disproportionate to the extent of the injury. 2d. That this danger exists independently of, though it may be modified by, the constitutional condition of either the one bitten, or the assailant. 3d. That there exists in the mouths of many, and always in the mouths of uncleanly

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individuals, decomposing materials which may produce poisonous properties in the saliva. 4th. That this danger is enhanced by the presence of tobacco juice, and the secretions of ulcers, carious teeth, etc.* 5th. That it is by no means settled that micrococci are the cause of the morbid properties of human saliva, for not all germs are possessed of properties for evil, and their presence would, in no case, be a refutation of the following proposition, viz: 6th. That the saliva may, and probably does, under the influence of anger, become possessed of poisonous properties, due, probably, to the presence of some organic principle allied to the ptomaines, and due to nervo-chemical changes which affect all the tissues and secretions in a manner differing in degree and not in kind.

Mooted Points in Syphilology.—Dr. E. L. Keyes records some interesting cases in the New York *Med. Jour.* The first bears upon excision of the syphilitic chancre as a means of prevention. He saw the papule twenty-four hours after its appearance and excised it thoroughly, taking away a generous amount of the surrounding tissues. The suspected person was seen and she had a syphilitic eruption. On the second day the wound had healed by first intention. After three or four days of premonitory fever, a mild roseola appeared and rapidly left. Two weeks later there was a profuse general papular syphilide, the hair was falling out and scabs in the scalp. No treatment had been given and it plainly indicated the futility of excising the primary lesion, even under unusually favorable conditions. The large number of cases published all point to the same conclusion. Whenever it is definitely established that the lesion is a true syphilitic one, excision proves entirely valueless.

Dr. Keyes gives drawings representing the teeth in a case of inherited syphilis and those in one of the acquired form. In the latter they are so similar that they would be taken, at first sight, as types of the Hutchinsonian teeth. The case is interesting as illustrating the fact that teeth very closely, if not identically, resembling the test teeth of Hutchinson may be possessed by a patient who has not inherited the disease.—*St. Louis Med. and Surg. Jour.*

We are of the opinion that entirely too much stress is laid upon this single case of excision of the chancre. We are about to publish the histories of ten cases of excision, which we have had in the last

* We are well aware that tobacco is said to destroy the germs produced by decomposition, but if this be true, it is counterbalanced by its irritating properties.

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two years, which seem to show that the operation has, to say the least, a certain curative influence upon the disease, and modifies its course. We have not yet seen a case in which we would be willing to state that constitutional symptoms were prevented, but the sum total of our observations tends to show that the operation is a useful measure, for several reasons, viz.

1. By removing the chancre we remove the principal source of danger to healthy individuals, a matter of importance to married persons.

2. We remove the chief source of discomfort to the patient, and obviate the possibility of inflammation and sloughing, with their attendant evils.

3. We remove a large number of syphilized cells, which would otherwise only be removed by the slow process of fatty degeneration, and removal by absorbtion and elimination.

4. We lessen the liability to extensive bubo, which may result if the chancre inflames.

5. We believe that we are justified in saying that treatment with mercury and excision, gives on the average, better results than mercury without excision of the primary neoplasm.

Excision of the pylorus—Dr. Randolph Winslow, of Baltimore, in the *Amer. Jour. of Med. Sciences* for April, 1885, has collected and analyzed all the recorded cases, eighty-five in number, of operative interference for the relief of pyloric disease. He fully discusses the different procedures, and presents the following conclusions:

1. In cancer of stomach not producing stenosis, anodynes, should be given in quantities sufficient to relieve distress and no operation should be performed.

2. Pylorectomy for carcinoma is followed by 76 *per cent.* mortality, hence it should only be very exceptionally performed in those cases where, with marked stenosis, the pylorus is not adherent to the neighboring organs, and the patient is young and fairly strong.

3. In other cases of carcinomatous stenosis, as only very temporary benefit can be obtained, gastro-enterostomy should be performed.

4. In cicatricial stenosis digital divulsion should be performed, but if this is impossible owing to great thickening of the walls, resection in those who are well nourished, and gastro-enterostomy in the debilitated will both be followed by good results.

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5. Hæmorrhage or perforation from ulcer or other cause than stenosis, does not present indications for pylorectomy.

6. Duodenostomy, gastrostomy for the passage of a tube, and complete gastrectomy should all be replaced by gastro-enterostomy.

The Bacillus of Syphilis.—In a former number of the *Journal* we noted the fact that Dr. Sigmund Lustgarten, first assistant to Prof. Kaposi, claimed to have discovered a method of staining and differentiating the bacillus of syphilis. March 27th, he read a paper before the Royal Imperial Society, of Vienna, detailing his method and a translation of this has appeared in the *Maryland Med. Jour.*, of April 11th, a copy having been transmitted in advance to that journal by Dr. Walter Wyman, formerly of this city. The method is as follows: Sections which have been hardened in alcohol are colored in a solution of gentian violet (Ehrlich-Weigert) from twelve to twenty-four hours at the ordinary temperature; and then for two hours at 104° F. The section, in order to be decolorized. is first washed in absolute alcohol for several minutes, then conveyed into a watch crystal containing about three c. c. of a 1½ *per cent.* solution of permanganate of potassa. It is allowed to remain ten seconds in this. It is then immersed in an aqueous solution of chemically pure sulphurous acid. In a very short time it appears entirely rid of its coloring matter in some places, whilst deeply colored in others. It is then washed in distilled water and placed again in the permanganate of potash solution, and after this to the sulphurus acid. After going through this process three or four times, it will appear colorless. It is then dehydrated with alcohol, rendered transparent in clove oil and ready for mounting in Canada balsam.

The method of distinguishing this from all other bacilli, lies in the fact that the bacilli of syphilis, of tuberculosis and leprosy are not decolorized by this method. Again the bacillus of syphilis is decolorized by nitric and hydrochloric acid, while the bacilli of the other two are not.

The bacilli themselves present the appearance of straight or curved, and sometimes irregularly bent rods. Under a low power their surface appears irregularly undulatory and slightly notched, and within them, at equal distances from each other, oval, colorless, bright spores, varying in number from two to four.

Some interesting facts in connection with this subject are given by Dr. Lustgarten. The examination of two chancroids failed to show

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the presence of the bacillus. In sixteen cases of syphilis examined, the result was positive in each. He regards the bacilli as the carriers of the syphilitic virus. An important fact is, that the occurrence of bacilli in the rete mucosum accords with the clinical observation that, in certain cases, syphilitic infiltrations need only lose their covering of horny epidermis to become contagious, becoming "moist papules."

The author regards his discovery as one giving in syphilis one which is of equal diagnostic importance to that of the bacillus of tubercle in the sputum of phthisis. He ventures to hope that a method may yet be found, by the cultivation of these bacilli, whereby a means will be successfully attained to combat the dread disease, as has been done in splenic fever and other infectious diseases.

That the discovery is of the highest importance to syphilology there can be no doubt. Pathological research in syphilis will doubtless be directed into a new channel and the few hints thus far thrown out by Dr. Lustgarten will fall upon fruitful soil, and we may expect ere long to be gratified with researches which will be of the highest scientific interest and practical utility.—*St. Louis Med. and Surg. Jour.*

We fear that there is some danger of the importance of Lustgarten's bacillus—if it be definitely proven to exist—being over-rated. As far as this particular disease is concerned, we can hardly see any practical difference between the results of inoculation with a bacillus, virus, or cell. Even the description of the bacillus given by Lustgarten himself, served to confirm the views of Otis, and others, who claim that the essence of the changes in syphilis is a modification of the normal tissue cells; for he asserts that the bacilli are found incorporated with the cells composing the syphilitic neoplasm. We may therefore content ourselves with the reflection that there is no practical difference between a proliferation of cells, due to an impulse imparted by a bacillus, and that induced by the action of a virus, or diseased germinal cell. We can readily see that any one but a skeptic upon internal antiseptics, would be inclined to hope for great things in the way of treatment, should Lustgarten's discovery be confirmed. In any event, we must not forget, while examining the bacillus, that it, in itself is of minor importance, while the consideration of the lesions produced by it, is the essence of the study of the disease. As for the production of an attenuated virus for "vaccination," we fear some difficulty would be experienced in its proving.

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Dermatology.

Edited by HENRY J. REYNOLDS, M.D., 2200 Michigan Ave.

Treatment of Chronic Ulcers of the Leg.—Every physician and surgeon has his perplexities in the practice of his profession. I have had many perplexities, but the management of old chronic ulcers, so frequently seen by the surgeon, has been to me one of the most difficult undertakings, until the last five years. Since that time I have adopted a course of treatment quite different from any laid down in our text-books. The plan adopted by me is that of sponge-grafting. The treatment is not original. I saw it mentioned in some medical journal about five years ago. Having had a case of sponge-grafting of a little different nature, it occurred to me that sponge-grafting for the cure of ulcers, and especially of the leg, would be worthy of a trial. About ten years ago I was called to see a young man (a carpenter by trade), who had driven a two-inch chisel into the inner side of his knee, cutting the anastomotica magna artery. The hæmorrhage was very great. Dr. A. A. Shobe, of Jerseyville, Ill., was called at the same time. Upon consultation we agreed to ligate the artery, but upon search for proper instruments for that purpose, we found we did not have them at our immediate command. The bleeding continuing profuse, I tore off a small piece of sponge, and grasping it in a pair of dressing forceps, dipped the sponge into a strong solution of tannic acid and crowded it into the cut. The bleeding stopped. I simply put on a common roller bandage, elevated the limb, and left the patient with instructions to keep quiet. I saw him every day for four days, and everything being all right, I did not remove the sponge.

Dr. Shobe, on the sixth day, insisted on the removal of the sponge. I made the effort at removal, but could only pinch off small pieces with the forceps, and in the pieces extracted I could plainly see the cause of the sponge adhering so firmly—the granulations had sprung up and insinuated themselves into the interstices of the sponge, and, having locked themselves fast into the sponge, when I would pull off a piece, I would break off the granulations and cause bleeding. I saw the best thing to be done was to let it alone. My patient was out in about fourteen days on crutches, and in about six weeks was entirely well. The sponge was removed only by absorption.

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Now I will describe my treatment for ulcers. The size of the ulcer makes no difference. I first cleanse the ulcer with castile soap suds, then dry it off, and, having previously prepared my sponge, I place it on the ulcer. The next thing to be done is to place over the sponge a piece of lead-foil sufficiently large to cover the sponge; then, over that a rubber bandage to hold the sponge and foil down in such a manner as to make equal pressure, but not so tight at the same time as to interfere with the circulation. The bandage and lead-foil must be removed twice a day, for the purpose of dressing the ulcer, being very careful not to lift the sponge out of the ulcer. I generally use for washing and disinfecting the ulcer and sponge the following: Equal parts of distilled water, glycerine and listerine, or the following: Aquæ dest., glycerini, aa ℥ ij; acidi carbolici, 95 per cent., ℥ ij. M. I use either of these by means of a small syringe. After dressing the sponge and ulcer in this way, I replace the foil and bandage as before. In a very few days you find the sponge will not fall off so very easily, for the granulations having sprung up and locked themselves into the interstices of the sponge, hold the sponge fast; at the same time absorption of the sponge is going on. So by the time the ulcer is healed the sponge is absorbed. This gives the doctor no trouble, and the patient can attend to it himself. Rest, at the same time is a very great desideratum, though I have cured many cases where the patient continued to follow his daily avocation. The preparation of the sponge is of great importance. I select a very fine sponge (a surgeon's sponge), wash it clean in distilled water, then immerse it in nitric acid, c.p., for the purpose of cleansing it of all lime or other earthy matter that may be in it, I rinse it through a half-dozen washings of water to get the acid out as nearly as possible; then I immerse it in carbolized water, when it is ready for use. The sponge must be cut a little larger than the ulcer, and very thin. The sponge acts at the same time as a protection to the granulations, and keeps them from being destroyed.—*Dr. Du Hadway*, in the *Weekly Med. Rev.*

Boils.—A boil is generally very small at first, and a fellow hardly notices it, but in a few days it gets to be the biggest of the two, and the chap that has it is of very little account in comparison with his boil, which then "has him." Boils appear mysteriously upon various portions of the human body, coming when and where "they darn please," and often in very inconvenient places. Sometimes a solitary

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boil is the sum total of the affliction, but frequently there is a "rubbish-in lot of 'em" to help the first one. If a boil comes anywhere on a person, that person always wishes that it had come somewhere else, although it would puzzle him to say just where.

Some persons call them "damboils," but such persons are addicted to profanity—the proper name is boil. If a chap has a boil he generally gets a good deal of sympathy from others—"in a horn." Whoever asks him what ails him laughs at him for his pains to answer, while many unfeeling persons make game of him, or of his misfortune, or boil. It is very wicked to make sport of persons with boils; they cannot help it, and often feel very bad about it. Physicians don't give boil patients much satisfaction as a general thing, although young physicians who are just beginning to practice are fond of trying their lancets on them. Boils are said to be "healthy," and judging from the way they take hold and hang on, and ache, and grow, and burn, and raise Cain generally, there is no doubt they are healthy and have good constitutions. They are generally very lively and playful at night, and it is very funny to see a chap with a good large one prospecting around his couch for a place where his boil will fit in "without hurting it." Boils tend to "purify the blood," strengthen the system, calm the nerves, restrain profanity, tranquilize the spirit, improve the temper and beautify the appearance.

They are good things for married men who spend their evenings away from home, as they give them an opportunity to rest their night keys, and get acquainted with their families. It is said that boils save the patient a fit of sickness, but if the sickness is not best to have, it must be an all-fired mean thing. It is also said that a person is better after he has them and there is no doubt that one feels much better after having got rid of them. Many distinguished persons have enjoyed these harbingers of health. Job took the premium at the county fair for having more achers under cultivation than any other person. Shakspeare had them, and meant boils when he said: "One woe doth tread upon another's heels, so fast they follow."

There are a great many remedies for boils, most of which are well worth trying, because, if they don't do any good they don't hurt the boil. Every man he meets will tell him of a "good thing" for it, among which are—shoemaker's wax, Mrs. Winslow's syrup, trix, Spaulding's glue, Charlotte russe, gum drops, water-proof blacking, night-blooming cerius, chloroform, kissengen, etc.—*Med. Age.*

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Alopecia Areata.—That alopecia areata depends upon the growth of a fungus is a doctrine that has been often advanced, only to be refuted, and has now few, if any, supporters. Nor can there be any doubt that mistakes have been made in the various attempts to settle what might seem to be a simple question, and certainly, among those who have upheld the parasitic nature of the affection, there has been little agreement as to the precise nature of the fungus concerned. It has been reserved for these days of microphytic pathology to revive the doctrine in a more refined form. Alopecia areata is due to the growth of a micrococcus, at least so says Dr. Von Schleu, of Munich, in a paper contributed to the current number of *Virchow's Archiv.* He describes five cases, in all of which the stunted and diseased hairs were mostly the seat of colonies of micrococci, averaging 0.5 m. in diameter, some smaller ones being of the diplococcus form, and larger ones with median constriction. From their situation in the shaft, it would seem that they occurred in connection with the ducts of the sebaceous glands, and it is inferred that they invade the hairs by these ducts. The micro-organisms were not found in any but the diseased hairs, and not universally in them. By cultures in agar-agar peptone it was ascertained that the organisms were distinctive in their mode of growth, and experiments were made with a view to ascertain whether they were really capable of transmitting the disease; on the human subject the attempt failed, but on white rats there appeared, on the spots where the material of some of the cultures had been rubbed in, scaly patches, over which the hairs at first became yellow-colored, and then fell out. The writer reconciles the notion that these micro-organisms have a causal relation to the affection, with the other well proved facts of its association with trophic disturbances (*e. g.*, vaso-motor derangements), by assuming that the occurence of such disturbance prepares the soil for the growth of the micrococcus. Holding such views, he advocates, and has had good results from, epilation and the use of corrosive sublimate; and also urges the importance of cleanliness in the use of brushes, etc., as a prophylactic measure.—*Lancet.*

Lupus Vulgaris.—*Salicylic Acid*—I have for some time employed salicylic acid, in the form of ointment, as a remedy for eczema of the scaly and impetigo contagiosa occurring in children, with the most gratifying results, cases that have defied other treatment yielding rapidly to its agency, and I have been induced to make further trial

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of it in other skin affections. By the kindness of Mr. Rigby, surgeon to the Doncaster Infirmary, I was permitted to employ it in a very bad case of lupus excedens, which had been for some time under his care. The patient, a woman, about 25 years of age, had her face terribly disfigured, the ulceration having destroyed one ala nasi, the whole of the cheek and eyebrow being also involved. She had been in the hospital before, and had improved under treatment with Donovan's solution and a visit to Harrogate. But on her return, although she was kept under observation and treatment, fresh tubercles developed, and the parts that had cicatrized soon became again involved and she was re-admitted to the institution. I first tried an ointment of 15 grains to the ounce of vaseline, which was of no use; I then increased the strength to a drachm, and then to a drachm and a half to the ounce. The ulcers soon began to heal, no fresh tubercles appeared, the cicatrices became soft and lost their shiny, unhealthy appearance, and the skin of the face is now almost sound. She was taking a mixture containing Donovan's solution and the liquor ferri dialysati. But as this had been administered without apparent benefit before admission, I think it is fair to give the credit to the external remedy. I have not heard of salicylic acid being employed before in the treatment of this particular disorder, and its action seems very satisfactory, especially as it does not appear to cause irritation.—*Dr. J. G. Marshall, House-Surg. Doncaster Infirmary, Brit. Med. Journal.*

Pruritus of Women.—*Local Treatment.*—All acquainted with the incessant suffering which some women undergo from pruritus at the period of the menopause, must be very desirous of being made acquainted with a prompt remedy for so distressing an affection. Whether it arise from the presence of prurigo, urticaria, eczema, herpes or whether it exists without any eruption at all, it is alike difficult to allay, as the great number of remedies which have been proposed testifies. Of these veratria is by far the most efficacious. When the pruritus is localised at the groins, arm-pits, walls of the abdomen, or behind the ears, gentle friction night and morning with an ointment, consisting of thirty parts of lard and a quarter of a part of veratria, usually gives relief. When the pruritus is generalised, the internal administration of the veratria is preferable. Two centrigrammes should be made into ten pills with liquorice powder, of which from two to six should be taken daily, either half an hour before, or three hours after

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meals. Only one should be taken at a time, an additional one being given each successive day until the maximum of six (three milligrammes) is attained.—*Dr. Chevon, in Le Progres Medical.—Med. Times.*

Psoriasis.—Arsenic and Soft Soap.—In the treatment of psoriasis, Prof. Neumann recommends arsenic, and in the form of the so-called "Asiatic Pills," which are composed thus: Arsenious acid, gramme 1.0; black pepper, grammes 5.0; acacia gum, gramme 1.5; with a sufficiency of distilled water. The ingredients must be thoroughly pulverized and mixed, and then enough gum arabic must be added to make 200 pills. Each pill contains 0.005 gramme of arsenic. These are to be taken each day at first, and gradually increased till ten or twelve are taken. The soft soap course, as an internal remedy, in the form of the "Pfeuffer'schen Cyclus," is strongly recommended in cases of universal psoriasis, and is thus carried out. The patient, undressed, is laid between blankets and is rubbed twice a day for six days, and once a day for three days with the ordinary soft soap, 100 grammes being used each time. The rubbing is conducted in such a manner that the whole of the affected skin is well rubbed each time, and, at each application, a fresh portion is rubbed with a hard brush in such a manner that the surface commences to bleed. The patient remains in woolen cloths night and day, and on no account is bathing allowed until the fourteenth day, and the longer this is delayed the more easily will the dried skin and soap be separated, and the less pain and sense of stretching will be experienced. In case the bath is taken too early, the skin will feel too short and tight, movement will be difficult or impossible, and rhagades are very likely to occur.—*Professor Neumann, Vienna, Brit. Med. Jour.*

Eye and Ear.

Edited by J. E. HARPER, M.D., 163 State St.

[The following extracts furnished by Dr. W. D. Babcock, Evansville, Ind.]

Carbolic Acid in Gonorrhœal Conjunctivitis.—In the Canada *Lancet*, Feb. 1885, C. Herbert Burnham speaks highly of the use of a 5-per cent solution of carbolic acid in gonorrhœal conjunctivitis. The patient is ordered to bed, and there is placed at his bed-side a large basin of ice water, with which the eye is to be frequently bathed, so as to cleanse it, while the cloths wet in the ice water are constantly to lie

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upon the closed eyelids. A carbolic lotion of the strength of one part in twenty is to be thoroughly and freely applied every hour, the lids being as well inverted as possible, and the patient at the same time directed to cleanse the eye as well as possible. The applications are to be made night and day. The pain and smarting which follow the use of carbolic acid last but a few seconds, and are succeeded by a feeling of comfort and relief. He also recommends this mode of treatment in other purulent affections, especially where the cornea is implicated, as in purulent infiltration of the corneal wound after the extraction of cataract.

Purulent Otitis.—Dr. Aysagner in the *Bulletin General de Therapeutic*, as quoted in the *Therapeutic Gazette*, gives three methods of treatment for purulent otitis. His routine treatment is, first wash the ear out with luke-warm water, then dry, and nine grains of finely powdered boracic acid are then blown in meatus against the tympanic membrane, the ear is then closed with borated cotton. The blowing-in is to be repeated each morning until the powder presents a dry appearance. This indicates a cessation of the discharge. At intervals of several days the blowing-in is to be done again, and if the powder remains dry for several days the discharge is supposed to be checked. In severe cases where the powder fails the alcoholic or caustic methods are tried. In recent cases the caustic first. The alcoholic consists in instillations of dilute alcohol gradually increasing to pure alcohol. The caustic begins with a fifteen grain solution of the salt to half an ounce of water, and get to two drachms to half ounce of water gradually. Oftentimes but one application of the silver is enough.

Exophthalmic Goitre.—Dr. A. D. Rockwell, April 7th, 1885, read a paper on this subject. He reports the treatment of fifteen cases, under the use of the galvanic current mainly; six of these were apparently cured, two decidedly improved, and one slightly benefited, two were not relieved at all, and four did not report. Prognosis in these cases he thought, ought to be more favorable than was generally thought. He laid stress upon (1) attention to diet and hygiene, (2) internal medication, (3) electricity. All excess in eating and drinking to be avoided, and the avoidance of all excess in every department of mental and physical hygiene, and the repressing of ordinary and legitimate emotions and passions become absolutely essential. A bland milk diet is to be recommeded. His experience suggests as the best internal

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medication a combination of iron, zinc, digatalis and ergot. All treatment must be supplementary to the constant current of electricity.

Granular Lids.—De Wecker in the same work states that he has derived benefit from syndectomy. He deprecates strongly the inoculation with the matter of purulent ophthalmia, though admits the beneficial results obtained by others. But this good he considers to be obtained at a disproportionate risk, whereas the inoculation with jequirity which he strongly advocates in preference, is, in his opinion free from the very considerable danger of suppurative keratitis.

Keratitis Phyctenular.—In a work on the eye published by de Wecker and Landolt in Paris, Wecker states that he finds the compressive bandage with the instillation of eserine or pilocarpine to be the most effective treatment in this trouble. Irritants are only resorted to when vascularzation has appeared; the use of atropine is restricted to those cases where there is a tendency to iritis and none to ulceration.

Glaucoma, Stretching Nasal Nerve for.—Dr. W. O. Moore recently showed a case upon which he had stretched the nasal nerve for the relief of glaucoma. The operation had been performed in New York city, three times with success. In one case known to the writer, there was a failure.

Wounds of Membrana Tympani.—Dr. Gorham Bacon, aural surgeon of New York Eye and Ear Infirmary, in the *Record* for April, 1885, reports seven cases of traumatic injury to the tympanic membrane. Where there is no discharge he does nothing, but where he finds pus insuflates boracic acid and gives calcium sulphide grain 1-10, four times daily.

Button Hook as an Eye Opener and Holder.—Dr. C. G. Roehr has for some time used the ring on a button hook for the purpose of fixing the eye so as to allow of working at or on the cornea. He uses a ring three-fourths inch in diameter. This device has enabled him to extract any foreign substance from the cornea without the usual difficulty of the patient winking or moving the eye.—*Med. Record.*

Earache.—By blowing a 4-per cent. solution of cocaine, atomized, into the eustachian tubes by Valsalvas' method, Dr. Henry Reder, of Aurora, Ills., succeeded in relieving a case of earache after hot water, leeches and paracentesis had failed.

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Editorial.

The Morphology of the Comma Bacillus—According to Dr. Jayne Ferran y Cluna, of Tolosa, Spain, the culture of the parasites of the cholera as well as the alvine evacuations in the same disease, are promptly covered with a mycodermic pellicle, composed chiefly, of bacilli. If a culture is made in meat-broth or in gelatin, spirillæ are developed. If conveyed therefrom into sterilized alkaline meat broth, fine spiræ endowed with great movement, are observed, which subsequently are transformed into flexuous filaments, always proceeding from Koch's microbium, for it requires only to be transplanted into gelatin to be transformed into comma bacillus. When a drop of liquid gelatin from the bottom of the cone in the tube of culture is examined, some of the spirillæ are found to have a small sphere in one of their extremities, which is better observed in meat-broth cultures. It is due to the concentration of nutritive activity in that part of the spira or filament where the sphere is formed, and which, gradually, grows to the size of a red-blood corpuscle. This sphere is formed by a protoplasm of closely uniformed refringency throughout its surface, and of a light blue-greenish color. Later on, this protoplasm contracts and leaves a part of the sphere empty, where a hyaline envelope (periplasm) fills its space. This periplasm is extremely diaphanous. The part of the sphere in contact with the filament of the spirillæ, is more opaque and has less perceptible movements and therefore a work of segmentation occurs, which terminates by the formation of very visible granulations. In the same filament where the sphere appears, at times, another, of smaller dimensions, is found, which never attains the same development, and probably constitutes the polinidium, or male organ of fecundation.

With close attention, after some time, the rupture of the hyaline periplasm is observed, after fecundation, when, as per magic, the vesicular walls disappear and the granulations are left afloat on the liquid of culture.

The evolution of the elements resulting from this segmentation, is as follows: Before the rupture, one of the granulations measures from $\frac{4}{10000}$ to $\frac{5}{10000}$ millimetres and the rest gradually decrease to the size of $\frac{5}{100000}$ of a millimetre. Some of these granulations placed in a favorable medium, will attain the size of a red-blood corpuscle, being

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transformed into mulberry-shaped bodies, others appear sterile, grow to large proportions, keeping always the homogeneous characteristics which, in the beginning, are common to all. The fecundated granulations, in proportion as they grow, assume a mamillary form, as if containing numerous nuclei; observed minutely, a tiny and long filament is noticed to spring from one point of the sphere, which attains the thickness of $\frac{5}{10000}$ millimetre and is of a light green. Frequently two filaments emerge at the same time. The filament is almost invisible close to its connection to the sphere, because of its transparency, but in proportion as it distances from it, becomes more evident, growing thick through a more active nutrition. At the time of separation, it is almost straight, but soon assumes the zigzag characteristic of the spirillæ; if cultivated, by scissiparous generation, all forms of bacilli described by Koch are obtained.

Here is the cycle of evolution: Spirillæ, protoplasm, periplasm, granulations, mulberry-shaped bodies and again spirillæ derived from these muriform bodies to repeat the evolution. There is also the scissiparous generation. Besides the spiroidal form, there is also filamentous, or simply, flexuous, but in the first culture of a series made in a fluid medium from colonies directly derived from the comma-bacillus of the dejecta of the cholera, extremely fine spirillæ predominate; the number of flexuous filaments grow in proportion as the series of cultures progress.

The fact that the finest spirillæ are those directly derived from the muriform bodies or its subsequent generation, which similarly occurs with the seed from the dejecta, lead us to believe that the primitive agent of infection of cholera in man, is not the comma-bacillus but the little muriform ovuli proceeding from the periplasm, which are eveloped in a coat sufficiently thick and resistent to protect them from the action of the gastric juice. Its reproduction is such that one single drop of culture is sufficient to infect, in six hours, a litre of meat-broth, at the temperature of 37° C.

Dr. Ferran has also made a discovery of high transcendency; that is, that the muriform bodies (mulberry shaped) develop even in acid medium, consequently the acidity of the gastric juice does not inhibit their arrival into the intestines, which should, in a living state otherwise occur with the bacilli, that offer but a feeble resistence against mediums of an acid reaction.

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The generation by segmentation can take place both with the spirillæ and bacilli.

Dr. Ferran's process of culture is as follows: Rich meat broth, sterilized, with the addition of a little human or hog bile and alkalinized by caustic soda, is the best medium of culture. The tube should be filled only to one-sixth, and maintained at the temperature of 37° C., after seeded. This should be continued for two hours after the broth has become cloudy, and then an equal portion of broth prepared as above, must be added to it, and kept in a cool place at the temperature of 15° C., the liquid being carefully neutralized as it grows acid at the expense of the life of the microbia. In these conditions the scissipurous generation is considerably moderated and the filaments existent in the medium become stronger, and more easily give rise to segmentation, which accomplishes, without pause, the above described cycle, unless the medium, prior to attainment of its last phase, should lose its assimilating principles. If incubation were made at a temperature relatively high, scissipurous generation would be so active, that it would exhaust the elements of nutrition of the medium, ere its full development.—*Coimbra Medico, May*, 1885.—*Trans. C. C. P. S.*

Miscellaneous.

Among the Springs and Summer Resorts on the Line of the C. & O. R'y.—The main line of the Chesapeake & Ohio railway extends from Lexington, Ky. to Old Point Comfort, Va., 644 miles. By recent extensions its western termini are Cincinnati and Louisville, while its connection at Charlottesville gives an additional eastern outlet at Washington. Blue Sulphur Springs are the first of the medicinal waters in the route eastward. There is a comfortable hotel, and this feature, together with the efficacy of the waters and pleasant surroundings, make it a very attractive resort for those seeking rest and quiet repose. Red Sulphur Springs are reached by a fine turnpike road from Lowell station; they are the only springs of the kind in this country, and there is but one other resembling them in the world—the Eaux Bonnes, in the Pyrenees. The analysis of the water shows that sulphur is by no means its greatest element, but phosphorus in a high state of potency has been most efficacious in reaching the seat of disease. Salt Sulphur Springs are reached from Fort Spring station, and are fourteen miles from the railroad; there is likewise an iodine spring, warmer than the pure sulphur waters, and thus an opportunity is given for variety of treatment; immediately around these springs are mountains of great extent and elevation, of which Peter's and Swoope's are best known by name, though all are a part of the Alleghany system. White Sulphur Springs, "the Baden-Baden of America," are situated in the famous "springs region," in Greenbrier county, W. Va., in a picturesque valley of the Alleghanies. The temperature during the summer months ranges from 60 to 75 degrees, rarely attaining 85; the medicinal virtues of the waters are world-famed, and have been tested since 1788; they have been used by thousands in various diseases, the distinct medical influences of the water being cathartic, diuretic and alterative; in rheumatism, dyspepsia, jaundice, hay-fever, and especially liver disease, it is a specific. The sulphur baths for gout, scrofula and skin diseases are attended with relief.

Alleghany, five miles from White Sulphur, is at the height of the mountains, and is 2,060 feet above the sea; the Alleghany tunnel, which pierces the mountain near this station, is 4,800 feet long. The station is the stopping-off place for several of the mountain resorts,

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the first in order being Sweet Chalybeate Springs, nine miles off by stage; one of the springs is so strongly impregnated with iron that it was given the name of Red Springs; from it is a flow of 800 gallons per minute. Never does the temperature vary more than 5 degrees, the range being from 75 to 79 degrees. Sweet Springs, ten miles by stage from Alleghany, ranks among the oldest of the Virginia springs; the waters are highly tonic in effect, with mild cathartic action, and are of benefit in diseases of the stomach or bowels, and in female complaints; plunge baths are a feature. Healing Springs are sixteen miles by turnpike from Covington; there are four medicinal springs, the temperature of the waters being 85 degrees, the flow unvarying throughout the year; they are chemically almost identical with the Schlagenbad and Ems of Germany, and similar to them in effects. Hot Springs are four miles from the Healing; in the opinion of some physicians the waters here are of more value than those of Arkansas, the latter being of such high temperature that they are unbearable to many, and in cooling lose much of their virtue; whereas, these waters at 110 degrees are available as they flow from the base of the mountain; there are six springs, varying in temperature from 50 to 110 degrees; for variety of baths these springs are unexcelled; plunge-baths, spout-baths, mud-baths, all are features of this resort. The diseases to which the springs are adapted, singly or in combination, are rheumatism, neuralgia, gout, paralysis, scrofula, skin and liver affections, nervous diseases, and female complaints.

Natural Bridge, reached by the Richmond & Alleghany railroad from Clifton Forge, is styled the eighth wonder of the world; the height is 215 feet, width 90 feet, and span 100 feet. Millboro Springs are sulphur in their nature, and have great success in a class of diseases that demand waters of gentle action. Wallawhatoola Springs are of alum and iron, in strong contrast with their neighbor, Millboro. These differences in neighboring springs are frequently met with in this medicinal region. Bath Alum Springs are at the base of the Warm Springs mountain, and the impression made by their location is that of shelter and seclusion; chalybeate, iron and alum are the chief agents. Warm Springs are four miles, through a notch in the mountains, from Bath Alum. The diseases in which the waters at Warm Springs have proved beneficial, are gout, rheumatism, paralysis, dyspepsia, liver diseases, neuralgia, and many female ailments; for nearly a century the Warm Springs have been highly esteemed by the profession. Cold Sulphur Springs are two miles from Goshen, and are much sought for dyspepsia and kidney and liver affections. Rockbridge Alum Springs are ten miles from Goshen, and are reached by the Victoria Railway; the diseases to which these waters are peculiarly adapted are chronic diarrhea, bronchitis, catarrh and many female ailments; their most signal success is in scrofula and dyspepsia. Striblings Springs are thirteen miles by stage from Staunton; alum, sulphur and chalybeate waters are here found in effective combinations. Rawley Springs are eleven miles west of Harrisburg, in the heart of the North Mountain region, and are 2,000 feet above the sea level; these waters are the strongest chalybeate of any in the springs region, and are also rich in iron combinations. Orkney Springs are 2,300 feet above sea level, and are five in number; they differ in their qualities to so great a degree that the invalid may choose that which is best suited to his malady. Luray Caverns are reached by the Shenandoah Valley railroad, and are considered marvelous beyond the Mammoth and other noted caves.

Newport News is seventy-five miles from Richmond, on the northern shore of the James river, near Hampton Roads; the locality is historic, the peninsula of Virginia having been notable ground ever since the settlement of Jamestown in 1607. During the hottest weather of summer a constant breeze prevails from the southwest, which in passing over the wide expanse of water is rendered pure and refreshing. Old Point Comfort, nine miles from Newport News, is the sea-side terminus of the Chesapeake & Ohio railway. During the winter the temperature rarely falls below 42 degrees, while in summer the heat is tempered by the ocean breezes to such an extent that the thermometer ranges between 60 and 80 degrees. In no section of the country will the seeker after health or pleasure be better pleased than in the country traversed by this line. It is a region of unsurpassed beauty, and it is a kind of beauty that is striking and facinating in the extreme.

W. R. Warner & Co. have received the first premium at the World's Exposition, New Orleans, for great uniformity and solubility for their sugar coated pills. This is the ninth world's fair prize which attests to their excellence.

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Medicine.

Edited by WM. E. QUINE. M.D., 3151 Wabash Ave.

Ferran's Inoculations and the Cholera Epidemic.—Notwithstanding all efforts at prevention and control, the cholera epidemic is spreading at the rate of nearly a 1,000 new cases daily, and already has destroyed nearly, if not quite 40,000 lives. Ferran is coming to be regarded as a bird of prey. The proprietary right that he has always claimed in his alleged discovery is so abhorrent to any respectable conception of the demands of humanity, that little else is needed than knowledge of his claim, to convince the most liberal minded of his heartlessness and charlatanry. It has never been easy to understand how a vaccination, or repeated vaccinations, can confer immunity from a disease, when a previous attack of the same disease gives, at best, but slight assurance that it will not recur. But now it is known that in the town of Aleria much more than one-half the deaths were among those who had been inoculated. It is also known that erysipelatous inflammation, and even gangrenous destruction of tissue, has not been of uncommon occurrence as a consequence of the operation.

A striking peculiarity of Ferran's experiment is the alleged fact that inoculation does not confer immunity from cholera until five days after it has been performed, and the immunity lasts for a very indefinite, but always small, number of days. Security, it would seem, is to be won by submitting to revaccination every few days at the hands of no one but M. Ferran. It is quite safe to assume that M. Ferran loses no opportunity to make hay while the sun shines.

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The Acro-Neuroses.—Under this technical caption Prof. C. L. Dana contributes an unusually instructive article to the July number of the *Medical Record* on the neuroses of the extremities. He classifies these affections as follows:

1. Vaso-motor and Trophic Disturbances.
2. Sensory Disturbances.
3. Secretory Disturbances.
4. Motor Disturbances.

He invites attention especially to the first two classes.

1. *Vaso-motor and Trophic Disturbances, Digiti Mortui, Erythromelalgia, Raynaud's Disease.*

Under this head he describes three cases, representing different degrees of severity, of the affection known as digiti mortui, or dead fingers.

CASE I.—The patient, a young man, complained that on slight exposure to cold the ring finger of one hand became white, waxy, bloodless, and cold. After a time, the circulation becoming restored, a burning and tingling feeling was experienced. Later the middle finger became similarly affected, and the affection was progressively invading the whole hand when arrested by tonic treatment.

CASE II.—A young woman was affected in the manner described, after exposure to cold, first in only one finger, but later, by a process of gradual extension, in all the fingers of both hands. In this case there was no burning or pain, and no blueness or mottling of the skin. The patient improved, under the use of iron, quinine, strychnia, and phosphoric acid, but still suffers in a measure from the attacks.

CASE III.—A young woman suffered three years ago from fugitive urticaria, and she now complains of frequent attacks of headache, and also of coldness of the extremities. The fingers at times get white and waxy, feel dead, then they get blotchy and purple, and the hand swells.

This affection, in its mildest form, is not uncommon among persons of a neurotic temperament. The severe type in which the fingers and hands get blotchy, and trophic changes occur, is less common. It is chronic in its course, intractable to treatment, and usually accompanied with burning pain. It is described by Dr. S. Weir Mitchell under the name of erythromelalgia, or red neuralgia, and

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by Raynaud, under the names of local asphyxia, local syncope, and symmetrical gangrene.

Erythromelalgia is a painful affection of the extremities, generally of the feet, accompanied by flushing and mottling of the parts upon slight exertion. It may attack the toes symmetrically and progressively. The patient suffers from an intense burning pain in the toes, ball, dorsum, or heel of the foot, extending even up the leg. Trophic changes may finally set in, and be associated with organic disease of the spinal cord. It occurs oftenest in males between the ages of twenty and forty years, after prostrating fevers, exposure, or severe exercise, and is very chronic and intractable. That it is not, as suggested by Ross, simply a form of sciatica, affecting the plantar branches of the posterior tibial nerve, is shown by the fact that it is often symmetrical and progressive, and that sometimes it affects the hands, occasionally being limited to them.

Raynaud's Disease belongs to the same category. The symptoms of a mild case have been given; those of a well-marked case are very striking. The patient suffers from paroxysms, in which the fingers, toes, and sometimes the ears, tip of the nose, and even tongue, become white and bloodless, and feel cold and dead; or, in other cases, venous stasis occurs, and the parts become blue and mottled. As the attack subsides there is pain of a burning character, and often of frightful severity. This is erythromelalgia. In many cases the disease does not advance further than this, but after a few months gradually disappears. In other cases a symmetrical dry gangrene follows, or it comes on directly. The gangrene is usually superficial and slight in extent, but the disease is apt to last for years. It occurs generally in women between the ages of eighteen and thirty, and has appeared, in different cases, to be related to malarial infection, diabetes, hysteria, and in very marked degree to scleroderma. The essential or direct cause is unknown. The disease can be easily distinguished from gangrenous ergotism, and from gangrene due to impaired nutrition, or to the action of escharotics, by its spontaneous development and its symmetrical and paroxysmal character. Raynaud states that galvanic currents to the back and extremities, supplemented by rest, tonics, etc., are very efficient in treatment, but he leads us to doubt their efficiency by insisting upon a due recognition of the chronicity of the obscure disorder.

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We are glad to say that Prof. Dana promises to continue his exposition of the subject.

Atrophy of Muscles in Pleurisy.—*The Lancet*, May 7th, 1885, likens the muscular atrophy which attends synovitis to that which occurs in infantile paralysis, and suggests the explanation "that the abnormal excitations proceeding from inflamed tissues have a direct influence on the trophic cells in the cord which control the nutrition of the involved muscles." The wasting of muscles of the shoulder and thorax, as a consequence of pleurisy, is assigned to the same category. This atrophy is said to play an important part in causing the deformities of the skeleton which follow pleurisy, and to constitute an indirect cause of pulmonary tuberculosis.—*The Med. Record.*

The Influence of High Altitudes upon Pulmonary Consumption.—Consumption is rare among the native population of New Mexico, and it is said by Dr. Archibald Smith to be an exotic in the Peruvian Andes at an elevation of 6,500 feet. Kuchenmeister and Lombard have estimated the altitude of approximate immunity in Switzerland at 4,000 feet, and at the equator at 9,000 feet; and Dr. Charles Denison has placed the altitude of comparative immunity at 6,000 feet.

The atmosphere becomes cooler, according to the elevation above the level of the sea, in the ratio of one degree for every two hundred feet. Heat depresses the nervous system and the respiratory function. In the tropics respirations number thirteen to the minute, and in temperate regions sixteen to eighteen. Hence a cool climate is desirable for those who have a tendency to the disease. Climate, however, comprehends more elements than temperature and altitude, and it is highly probable, as suggested by Loomis, that purity of atmosphere is entitled to as serious consideration as a means of protection, if it does not outweigh them in importance.

Agraphia.—At least as far back as 1856 it was pointed out by Marce that in cerebral injuries the faculty of writing might be lost, just as the faculty of speech is lost, without any loss of muscular power or mental competence; that there is in fact a condition of agraphia or "aphasia" of the hand. M. Pitres devotes an interesting essay to its consideration. The analysis of the faculty of memory as applied to language, which disease enables us to make, is in three divisions, viz.: of sights, of sounds, and of muscular movements. Each of these may be abolished, leaving the others intact.

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First, if memory of sight alone be lost, a man can hear, and write, and speak, but cannot read what he has written. He may, however, by an ingenious artifice, gain knowledge of what he has written by using his surviving memory of muscular movements; if he makes his hand trace out the forms of the letters lying before him, which are meaningless to his eye, by his recollection of the movements he recovers knowledge of the word written by them. It seems likely that there may be loss of parts only of this visual memory; that he may forget the meaning of printed letters and remember handwriting; or forget words and remember musical notes.

Secondly, if the memory of sounds be lost, a man may speak and read and write and hear words, but not understand their meaning when he hears them. In the third place, if memory of muscular movements alone is lost we have pure motor agraphia; the man can speak, and hear, and understand, and move his fingers easily, but he cannot write, for he cannot recollect the necessary associated movements. Of a case of this kind M. Pitres gives very full details The man, in July, 1882, had sudden right hemiplegia with aphasia, and improved rapidly under energetic anti-syphilitic treatment. His aphasia disappeared completely, to begin with, and he recovered the use of his limbs slowly and nearly entirely.

In February, 1884, eighteen months after the first apoplectic attack, he came under the care of M. Pitres at Bordeaux, and his symptoms were very carefully observed. The left leg and left arm were stronger than the right leg and right arm, in the ratio of three to two, and seven to six, respectively. There was ankle clonus on the right side, and increased deep reflex in both arm and leg. The right side was slightly colder; there were chilblains on the right hand, but not on the left. With the right hand he slightly underestimated weights, and there was a slight loss of muscular sense in some particulars, *e. g.* when blind-folded and told to hold out both hands at the same level he always held the right hand a few inches higher than the left; however, he could touch his nose accurately and quickly with his right hand, and if his hand was held and moved in the air after the fashion necessary to write a word he could read the word easily from the movement.

There was no relic of aphasia; he could read handwriting and print quite normally. The agraphia of the right hand was what annoyed him. He had learned to write with the left hand, but not a letter

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could he form with the right, except when he painfully copied what he had already written with the left, with an appearance of tracing out unfamiliar forms with constant comparison with the pattern. The awakening of muscular memories by writing a word with the left hand was not enough to enable him to write it with the right; it was necessary he should have it before his eyes to copy. If he was told to *write* a *printed* word lying before him he formed his letters like those of the print, and could not transcribe it in cursive characters. Nevertheless, if told to draw a triangle, or octagon, or other geometrical figure, or even a human face, without any pattern, he could do it readily with his right hand. And in spite of dilligent attempts he made no progress in writing in the next eight months.

Such symptoms constitute pure motor agraphia, or graphoplegia, as it may be called, in correspondence with the logo-plegia of aphasics. Its cerebral point of origin M. Pitres is inclined to put, with M. Charcot in front of Broca's centre. Its extent is so small that an injury very rarely affects it alone, and is very apt to include the aphasic centre at the same time, so that the symptoms become obscured — *Pract.—Review de Med.*

Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

Another Antipyretic.—Thalline is derived from chinoline, discovered by Skramp and first employed by M. Jacksch, of Vienna. All the salts of thalline are easily soluble in water (tartrate, sulphate, chlorhydrate and acetate), the chlorhydrate is rapidly affected by the light; the sulphate is the most frequently used in therapeutics; it is soluble in five times its weight of cold water; the tartrate is soluble in ten parts of cold water; ethylthalline and its salts are equally soluble in cold water. The concentrated solutions of thalline have a bitter and saline taste; the diluted have an aromatic taste.

M. Jacksch, the discoverer of the antipyretic action of thalline, employed the chlorhydrate, sulphate and acetate of thalline and the chlorhydrate of ethylthalline in doses of twenty-five, fifty and seventy-five centig. The lowering of temperature is considerable (several degrees), it, frequently, coincides with a sweat; a chill precedes the elevation of temperature. Collapse has never been observed, but

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there is, at times, an increase of blood pressure and a decrease of the pulse and respiration. The minimum of temperature is noticed from two to three hours after the administration of the medicament, which has, otherwise, no influence upon the progress of the diseases wherein it is used. The action of thalline is more durable than that of kairine; more active (25 centig.=1 gram.) than antipyrine; but the effect of the latter is more lasting. In rabbits, the thalline salts in doses of 60 to 80 centig. have no toxic effects; in the healthy man, in the doses of 50 centig. to 1 gram. they are inert. All the salts of thalline are antiferments; their elemination is through the kidneys.

The experiments of M. Alexander with the tartrate and sulphate of thalline, at the clinics of M. Bienmer, coincide with those of M. Jacksch. Their effect with the dose of 25 centig. only lasts about two hours, and it should be repeated every two hours if a permanent action is required.

The acetate of thalline has been used by M. Grocco (of Pavia) in the dose of 25 centig., with a powerful anti-pyretic action; its administration is followed by profuse sweat, slowing of pulse and respiration. When the stomach is intolerant, he gives it hypodermically, in 10 centig. doses. The average action of this salt lasts from four to six hours.

The sulphate and tartrate of thalline in the dose of 75 centig. in three doses, one every three or four hours, reduce the temperature, according to M. Mingassini, from 3° to 3.8°, its action lasting from eight to twelve hours. By the rectum its effects are the same as by the stomach. The same author has used the sulphate of thalline, hypodermically, in the proportion of one gram. to five of warm water, administered warm, for it precipitates otherwise, and has observed neither abscesses nor other local accidents. The dose of 10 centig. (equivalent to 25 centig. by the stomach), causes a lowering of temperature of from 2.1° to 3.1°, lasting from six to nine hours. M. Pisenti accords with M. Mingazzini in the exemption of dangerous accidents by the hypodermic use of the aqueous solutions of sulphate of thalline.

In *resume*, thalline has, over antipyrine, the advantage of small doses, feebler taste and odor, and seldom provocation of vomit. Antipyrine, has, on the other hand, the advantage, over thalline, of more prolonged action, ordinary absence of chills, lowering of the pulse in relation with the temperature and finally, according to some authori-

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ties, its favorable action on the joints in acute articular rheumatism. —*Le Progres Medical, 16 Mai, 1885.*

Depurative Drops.—℞. Tinc. iodi, four gram.—Tinc. nuc. vomica, one gram. — Liq. pot. arsen., one gram. M. S. Five drops, in sweetened water, at bed-time, in syphylis complicated with scurvy, and lupus influenced by a syphylitic diathesis. Increase one drop every three days until arriving at the dose of fifteen drops, which should never be excelled.

Laryngology.

Edited by GEO. F. HAWLEY, M.D., 125 State St.

A Contracted Larynx Improved by Schroetter's Dilators.—The dilating of a contracted larynx by means of olive sounds as has been stated in a previous article, has given most satisfactory results in the hands of the Germans. The same cannot be said however in France. Although my bibliographic researches have not been very extensive, I can however furnish proof of this assertion. First the testimony of Mr. Collins through whose great kindness I was able to obtain the instrument employed by Prof. Schroetter, of Vienna. Mr. Collins brought this instrument from Vienna, in the hopes that it might be used in Paris. The instrument however, remained neglected among his others; perchance he experienced the same difficulty which one finds in handling a new instrument. In fact the dilator of Schroetter, which to-day I find useful, I was not able to use last year when I endeavored to use it upon a patient who was sent to me by my confrere and friend Dr. Petitclerc notwithstanding I had practiced upon him catheterization of the larynx by metallic bougies at his home.

Dr. Etchebame in his inaugural thesis of 1878, upon the membranous occlusion of the glottis does not cite a single case where this manner of dilating the larynx has been employed in France.

Dr. Poyet in his manual of laryngology published in 1883, in speaking of the operation of Stoerck (who employs a hollow instead of a solid sound) said that in contraction of the larynx we can try forcible dilatation, but as it never has been attempted, he could not appreciate its worth. The instruments for dilatation, which have been mentioned in the articles of French writers, that I have had an op-

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portunity of perusing, are, the polypus forceps of Fauvel and gum and metallic bougies.

I believe therefore that the statement, which I am about to give you is of true interest on account of the excellent results, although incomplete, which I have obtained by means of one treatment. It is old 'tis true in Germany, but new among us.

The history of my patient may be perchance a little long to present with all its details. Therefore it behooves me to note the more important facts.

M ——, 35 years. A coal heaver upon a merchant vessel. On account of the high temperature, to which he is exposed, generally works nude to the waistband. This is necessary to be mentioned, as it plays perhaps a certain role in the localization in the larynx of the disease for which he is afflicted.

This man came to consult me on the 1st of July, 1884; he presented already all the signs of a contracted larynx, respiration wheezing and slightly stridulous, voice harsh. On account of the difficulty in breathing the laryngoscopic examination which I made that day was incomplete. I was unable to see the open glottis in all its extent. It was therefore impossible for me to determine what lesions existed on the side of the larynx. The history however, enabled me to diagnose the affection of syphilitic origin. In fact, this disease manifested itself afresh two months ago (May, 1884). The voice was altered, the breathing began to be difficult and wheezing, the approach of suffocation was apparent. He had not a single symptom of pulmonary tuberculosis. There had never been enlarged glands or bloody expectoration, which might indicate cancer, while one could find from the previous history of the disease; indications of syphilis. Upon the gland penis, I found a cicatrix due to a chancre contracted at 17 years of age. In 1881, there came suddenly beneath the left breast a large black swelling, which slowly ulcerated, accompanied with nocturnal pains and which after existing three months, with no tendency to heal cicatrized quickly by the use of iodide of potassium. It left a cicatrix adhering to the side and of an irregular shape, like cicatrices following sepigenius ulcers. I advised the patient to continue the iodide of potassium, which had already been given him by his physician Dr. Carnus, of Louviers, and to have tracheotomy performed if the trouble of breathing increased.

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July 18, 1884. The patient arrived at the General hospital about eleven to put himself under my care. As soon as it was morning he quickly departed in a carriage into the country, distance about seven leagues, after having passed a very miserable night and constantly demanding the operation. Since my first examination the difficulty of breathing had increased; he had not been able to sleep for three nights, and had been on the brink of suffocation, during which time his wife said he acted like one crazy, ran out of his house, tore open his shirt that he might obtain all the air possible. The wheezing was marked; it could be heard from one end of the saloon to the other. The patient in great torture demanded at once the operation. The difficulty in breathing was manifest; there was a complete absence of respiratory murmur. I performed tracheotomy in the afternoon and placed in the trachea an ordinary canula number 4 of Luer. The relief was immediate. During the first four or five days which followed the operation the patient presented symptoms of a slight bronchitis.

July 25. The respiration was no more difficult, the examination of the patient became easy, and I could confirm my previous diagnosis. In fact the auscultation impossible before the operation showed the respiration normal, and that there existed at the apex of the lung not a single lesion of tuberculosis.

The laryngoscopic examination showed closure of the larynx due to immobility of the right arterial cartilage and incomplete movement of the left. Slight œdema of the ary epiglottic fold. Immobility of the vocal cords, adducted one to the other, no ulceration visible. The anti-posterior diameter of the larynx appeared diminished.

Sept. 13. General health good. After tracheotomy, notwithstanding the anti-syphilitic treatment by Gebert syrup and iodide of potash the contraction of the larynx continued to increase; it reached such a point that the patient after removing the tube and closing the artificial opening could neither speak nor breathe through the larynx. It seemed to be completely closed. I concluded that the ulceration had begun to heal and that this laryngeal lesion was due to the contractions of the cicatricial tissue. Catheterization was commenced by means of a Benique number 35, at the same time the patient was provided with a valved canula in the hope that the air might pass through the larynx.

Oct. 10. I passed a number 51; the patient was at once able to speak for several seconds.

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Nov. 1. I was able to pass a number 60, which has a diameter of one centimetre; the manner of catheterizing was as follows: I first passed a number 45, then 51, then 56 and 60.

Nov. 7. The catheter was used daily; the bougies were introduced and left several seconds before withdrawn. The improvement thus obtained, though apparent, did not remain more than two minutes, after which the patient was unable to speak. On account of this unsuccess with the ordinary catheter I decided to use that of Schroetter. Permit me to recall the different pieces of which it is essentially composed. There are:

1. Sounds of tin with a triangular form, angles rounded and having at their upper extremity a thread by which they can be withdrawn from the larynx.

2. A handle upon which is placed one of the sounds of tin, and, which serves finally to carry it into the larynx.

3. A small pair of pinchers which enter the tracheal tube sufficiently to fix the inferior extremity of the plugs when introduced.

I introduced the sound number 2, of Schroetter's, of which the diameter is the same as Benique number 47.

It was decided that the patient should retain it, if possible, for two hours.

Nov. 8. At my great surprise the patient began to speak as soon as I approached his bed. It was clear that the benefit obtained by this manner of dilatation was permanent, as the sound had been removed for twenty hours. The two hours of prolonged dilatation with Schroetter's instrument had done more than the short operations practiced with Benique's, though repeated every day for nearly two months (the catheterizing began Sept. 13). The voice was still rough as it was before tracheotomy. I then introduced a number 4, then a number 6 sound.

Dec. 2. The patient for moneyed reasons was obliged to leave the hospital, but was well satisfied with the result obtained. It seemed to him that he gained something every day, and he promised to return when he was able, to obtain if possible a complete cure. He wore the canula with the valve during the whole day's journey, only removing the valve at night; he walked and talked without fatigue.

The larynx was changed in a remarkable manner. The anterio-posterior diameter was lengthened and appeared normal.

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The vocal cords are still immovable, and their appearance resembles a button-hole opened. The right arythenoid is also still immovable; the left executes a slight see-saw movement.

Jan. 2, 1885. The patient returned to the General hospital, after a month's absence; he had lost nothing of the relief obtained; he spoke with his valved canula in position and only removed the valve at night or to take a long or rapid walk.

During his absence I had had made by Mr. Collin two sounds larger than those used, in the hope of obtaining a dilatation so that it might be possible to remove the canula completely, and permit the tracheal wound to heal. I do not know if I shall obtain this result; I was in hopes of being able to show you the patient later, but I fear that he may be obliged to leave the hospital before the February meeting.

As a preliminary treatment I ought to note some cauterizations with a fine point of a thermo-cautery, in order to check and destroy the fleshy growths which developed at the inner aspect of the tracheal wound, and to which I have already drawn attention in cases of tracheotomy made necessary by croup.

When a catheter enters the laryngo-tracheal canal it pushes before it these fleshy growths which hide a part of the dilator, and in localizing itself takes the form of a membrane whose lower free border presents a concavity beneath, and resembles slightly the veil of a palate, minus the uvula. On the contrary, when the catheter is removed and a canula is introduced, this in penetrating into the trachea, pushes up in a manner opposite to the dilator, this membrane which tends to grow horizontally and aids to close the lumen of the trachea if not destroyed from time to time.

The catheterization of the larynx does not seem to be painful, although I have practiced it without a preliminary anesthetizing of the larynx. My patient never told me that I hurt him, and he was the first to ask me to push the instrument more vigorously when the sound seemed to enter with difficulty.

This sensation indicated by the patient that the instrument was properly placed, was moreover for me an important guide, for though at the first operation, which consisted in placing the end of the dilator at the glottic opening, was made by the help of the sight. The second (that is to say, the act of passing the constriction) was made without recourse to a laryngeal mirror which had been removed. I am

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then guided by the sensation of the patient, and by the appearance of a slight cough which shows me that the instrument passes the vocal cords; immediately after I am able to see the end of the catheter at the tracheal opening. When this little cough is not produced, notwithstanding the pressure which I employ to cause the instrument to enter I conclude that the instrument is out of place and without persisting I remove it in order to replace it in a different direction.

Nevertheless, on account of the difficulties which I have experienced during the first times, I believe I can say that catheterizing the larynx is a difficult thing, especially if one is illy provided with instruments.

One of the difficulties to guard against is the flowing of the saliva into the pharynx, which often occurs the instant one proceeds to use the laryngital mirror and it is in a certain way by a rapid movement that the dilating instrument must be introduced into the larynx, which ascends as it were toward you.

If in consequence of some defect of light where by a hesitancy in the introduction of the catheter causes nausea, which produces a flow of mucus before the instrument has been well placed, it is necessary to recommence the operation after having given the patient time to expectorate or swallow the saliva.

A good light is necessary to succeed well and in this relation I find the "photophore" invented by our colleague Dr. Heloy, and made by Mr. Frouve very convenient. My first attempts at catheterizing have been made by the light of a large lamp, and it is, perhaps, to the insufficiency of that light that I ought to attribute my misfortune in the first attempt, which I made on Dr. Petitclerc's patient to introduce Schroetter's instrument, the patient afflicted by a contraction of the larynx together with a perforation of the hard palate.

The larger the catheter, the more difficult becomes the operation because the field of the operation is hidden by the instrument.

I will say likewise, some words on the curvature I have given the probes which have served me for catheterizing preparatory to the dilatation by Schroetter's method. It is after much hesitation that I have come to adopt the curve, which the instruments I use now have. I had first imitated wholly the curve of the forceps for polypus of Mr. Fauvel; but the length of the bent portion is insufficient because the catheter ought to traverse the entire length of the larynx, and also, perhaps the first tracheal ring. The tin probes which I have used are

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some of Benique's, bent in the middle by a curve much rounded, and in such a manner that the two branches make a right angle.

From this observation I believe I am able to draw the following conclusions:

1. The catheterizing of the contracted larynx is not painful.
2. The retention of the instrument between the vocal cords neither causes inflammation nor alteration in the voice.
3. The dilatation of the larynx in order to be successful should be permanent and prolonged.
4. The benefit obtained by the instrument has remained intact a month without any new sittings for catheterization.
5. If at the beginning one experiences some difficulties in the use of Schroetter's dilator, they are not long in disappearing.
6. The use of Schroetter's dilator is facilitated by the introduction of Benique's tin probes, to which are given an appropriate curve.—*Dr. Petel in Jour. de Med. de Paris, Translated by Dr. G. F. Hawley.*

(Mr. Petel ends his communication by presenting his patient in whose larynx he had placed for eight hours previous Schroetter's sound number 6; a thread of firm silk fixed at the upper extremity of the sound comes out of the mouth and is fastened around one ear. In order that this thread may not be cut during mastication the patient takes only soft food during these hours. The lower extremity of the sound is pressed into the opening at the convexity of the outer canula, which alone the patient wears and is fixed in this position by Schroetter's little pincers. The pincers are then drawn out and the sound is removed by a light traction of the thread. The patient when they remove the internal canula which bears the valve can speak immediately.)

Removal of Naso-pharyngeal or Fibrous Polypus.—Turneaus Jordon, F. R.C.S., operated for this kind of tumor thus: By making a triangular flap out of the upper lip and side of the nose. A curved bistoury is carried under the lip into the affected nostril and made to cut its way out. Then the soft part of the nose is divided on one side of the middle line in a line with the cut in the lip. Turn flap well outwards. To and fro traction by one or two fingers in the pharynx and one or two of the front aided perhaps, by a snip of sissors or knife readily detach the tumor, which falls in the mouth. If opening be found too small use bone forceps. * * Probably similiar incisions would be found very useful in cases where the nostril is filled with ordinary,

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but obstinate and crowded polypi and also in cases of malignant polypus, where it is deemed well to clear the nostril for a time.

This seems to be rather a formidable operation for such a growth. If Professor Jordon had had a Jarvies' snare or a Bosworth's combination of Blake's ear snare and Jarvies' straight snare which is much better, he would have had no need for so extended an operation. The writer's first case of polypus was one where the right nostril was stuffed full of polypi; with the snare he removed, at three sittings fifteen polypi, the smallest as large as a field pea and all of them through the anterior nares, with not over a loss of a teaspoonful of blood. The next case four large polypi the largest three-quarters of an inch long, one-half inch wide, and the smallest one-half inch long and three-sixteenths of an inch wide and drew only ten or fifteen drops of blood, and through the anterior nares. The experience of the American practitioners as recorded in the various journals show that very large tumors, larger than any of the openings can be removed by either the cold or red-hot snare and without the use of the knife.

Diphtheria.—In a report of eight cases of diphtheria by H. C. Alderton, of London, he had the best effect from the use of syrup of hydrate of chloral locally with soda sulpho-carbolate and stimulants internally. The syrup of chloral removed the livid condition of the throat, and the pain of swallowing seemed to be less.

Dermatology.

Edited by HENRY J. REYNOLDS, M.D., 2200 Michigan Ave.

Vitiligo.—A paper was read on this subject at the recent annual session of the Ohio State Medical Association by R. Harvey Reid, M.D., of Mansfield, Ohio. The paper contained a general description of the disease, a report of four cases, and points of differential diagnosis between this and the other diseases with which it is most liable to be confounded, viz.: morphœa, chloasma, tinea, versicolor and lentigo; which, being very complete, interesting and instructive we give in full.

VITILIGO.

Chalky-white or pinkish-white spots varying from one to scores, of irregular shapes and sizes, sur-

MORPHŒA.

Usually commencing with one or two isolated round or elongated pinkish or purplish spots, sur-

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rounded with an areola of brownish yellow of varied intensity, which often coalesce.	rounded with a pinkish or violet border.
The skin is smooth and the outlines of the spots well defined.	The skin in the earlier stages is elevated, later may be on a level or still more advanced, depressed below the surrounding integument, and the outlines not well defined.
The skin feels normal to the touch and the secretions of the derma unimpaired.	The skin becomes dry, has a polished look, or is often shriveled, while the secretions of sweat are either diminished or suspended altogether.
No pain nor irritation of any character.	Often associated with a tingling pain or numbness.
Has little or no tendency to recovery, spontaneously or otherwise.	While of a chronic character, has a tendency to spontaneous recovery.

With these few landmarks to guide us, and at the same time remembering that in vitiligo there are no structural changes in the derma, while in morphœa there are, there will be little or no danger of mistaking the one for the other.

I have in two instances seen vitiligo mistaken for chloasma, notwithstanding the following characteristics between these two diseases:

VITILIGO.	CHLOASMA.
There is loss of pigment in one place, with increase of pigment in another.	There is simply increase of pigment in one place, but no loss in any other.
May occur in either sex and at any age or time.	May occur in either sex, but is much more common in the female than in the male, and after puberty than before, and during pregnancy or menstruation than at any other time.
The prognosis is usually unfavorable.	The prognosis is more favorable and especially so when due to uterine disturbances.

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If there is any question existing between vitiligo and tinea versicolor, the microscope will readily clear that up; for in tinea versicolor as in chloasma there is no loss of the pigment and really no increase of the true pigment, but a brownish discoloration of the skin from the presence of patches of the microsporan furfur, which gives the skin a mottled appearance.

These brown spots can be easily removed with the finger nail, however, by moistening them for a few minutes and scratching them gently, and when placed under the microscope will readily enable you to distinguish between them.

It is almost impossible to confound this disease with lentigo or common freckles. The size and shape of the spots, and the want of the characteristic chalky appearance of vitiligo, together with the rapid increase of lentigo by exposure to the wind and sun, which does not affect vitiligo, would readily enable the most careless to distinguish between these two diseases.

The results of treatment in the four cases reported by the author were much the same as that of other observers, unsatisfactory. Some of the cases it was thought were helped some by the use of electricity.

Record of a Case.—The following was presented at the College of Physicians and Surgeons by a man engaged at laboring work in connection with one of the railway depots of this city, as what he called a statement or record of his case; the trouble for which he sought medical advice, being headache. The record was in the form of a diary in his own hand writing.

March 26th, 1885. Headache all day.

April 2d. Headache in the afternoon.

April 17th. Slight headache at 6 A.M.

April 20th. Slight headache at 5 A.M., to next morning.

April 21st. In fact, it made me sick.

May 23d, Saturday, 1885. Headache all day, almost blind through it. Slept last night in the chair. Blinds me to read.

Sunday, May 31st, 1885. Headache all day, almost blind through it. Tramps are going and coming in every direction.

Sunday, June 7th. Headache all day, nearly blind through it. Rained in the night from 8-30 to 10 P.M. I am costive and painful to-day. With great difficulty I had a passage and after the passage my fundament felt sore and ached, in fact, I felt sick, yes, I felt sick.

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June 10th, Wednesday, S.B., 1885. Headache all day caused by the smell of paint in a newly painted room. My head aches now, at 4 P.M., just as bad as it did at 4 A.M., this morning.

Thursday morning, June 18th, 5 P.M., 1885. Headache. Although I rent a furnished room,—cause—not sufficient air. Room shut up all day. I spoke to Bartlett about air.

Sunday, June 21st, 1885. Headache this A M.

Monday, June 22d, 1885, S.B. Rain, cold at night. Pain in right side—cause, not covering enough, only one comforter over me; fire in stove. Headache; work scarce, slack times. Six to a dozen tramps going west every day to Dekalb to work on a branch railroad, from Dekalb to ——.

Tuesday, June 23d, 1885. Headache and poor appetite.

Thursday, June 25th, 1885, S. B. Headache from 4 A.M., this morning until 6 P.M., and I have it worse than I have yet had it. I am almost blind through the severity of it. It comes on me every third day. Tramps on hand.

Monday, June 29th, 1885. No headache since last Thurday. I had 4 (four) stumps and roots pulled from the right side and one stump from the left jaw by L.L.D., D.D.S., at the College of Physicians and Surgeons. I endured the operation well through the divine assistance of the almighty God. May our blessed Lord prevent the return of such pain again. It was 3 P.M., and when all was over I wept through grief.

This morning, June 30th, Tuesday the side walk is white with frost at 4-30 A.M., and I made a fire. Headache since noon and at this writing 7 P.M., I have it badly and feel also chilly. H. J. R.

Mosquito-Bites.—One drachm each of spirits of chloroform and spirits of camphor, and two grains of corrosive sublimate, in four ounces of water, will allay the irritation caused by mosquito-bites.—*Med. World.*

The Hair Falling Off.—F.R.C.S. writes: There are several things to be inquired into before treating such cases. "Is there any syphilitic taint?" I have met with cases where the hair has fallen through being tied up so very tight. The excessive strain causes the hair to break, the nutrition of the hair-follicles being destroyed. How often does the patient wash the head and hair? This is very important. Has the patient suffered recently from some illness, as scarlatina, anæmia, etc.? Often the hair falls off, unless two or three inches be cut off at once. If none of these causes can be traced, he would re-

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commend the following liniment: Dissolve one grain of cantharidine in two drachms of acetic ether, and add rectified spirit ʒ iii., castor oil ʒ i., and oil of lavender fifteen minims. Mix well. Apply this to the roots of the hair for three days successively; then the head should be thoroughly washed by an attendant, so as to have plenty of friction, with a good lather of warm soap and water, otherwise, the lotion may accumulate, and cause too much irritation.

Dr. V. Poulin recommends a lotion of one grain of antimonium tartaratum to an ounce of distilled water. This was a favorite remedy with Prof. Chelius for alopecia.—*Brit. Med. Jour.*

Treatment of Ringworm of the Scalp.—The following is a very simple and effectual method of treating ringworm of the scalp.

The child affected is made to sit down before a wash basin half filled with warm water. A folded towel is first of all tied around the child's forehead, in such a way that no fluid poured on the head can trickle into the eyes.

It is best to cut the hair short all around the affected part. If there be many spots of ringworm, the whole head may be closely cropped. Have ready a two-ounce bottle of common spirits of turpentine, an ounce bottle of tincture of iodine, a camel's hair brush, and cake of ten per cent. carbolic acid soap.

While the child bends forward over the basin, the spirits of turpentine is freely poured over one or more spots at a time, the forefinger being used to rub the turpentine well into the scalp. Almost immediately the dirt and greasy scabs disappear, and the short broken hairs are seen to stand up like bristles. Generally, in about three minutes the child cries out "Oh, it nips!" and we know the turpentine has penetrated deeply. Immediately the piece of carbolic acid soap is rubbed well into the parts which have been acted on by the turpentine, and warm water is freely applied to make this soap into a lather, by which means the head is well washed, and soon appears to be beautifully cleaned. The smarting, such as it is, quickly disappears. The head is then well dried with a towel. Common tincture of iodine, in two or three coats, is now painted well over the affected parts, and allowed to dry. As soon as the hair is dry, some carbolic oil (1 to 20) is rubbed through the hair to catch such spores as may be there.

This treatment, applied every morning, or morning and night in very bad cases, generally cures the worst cases in the course of a

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week. During the last five years I have used no other method of treatment. The explanation of its success is as follows: Common spirits of turpentine is a powerful germicide, but is a still more powerful solvent of the sebaceous or greasy matter of the scalp, and it rapidly penetrates into all the epithelial structures of the scalp, the affected hairs included, and clears the way for a more powerful germicide, namely, the tincture of iodine.

It is an interesting chemical fact that spirits of turpentine, or more correctly, oil of turpentine, is a powerful solvent of iodine. This quickly destroys the fungus of ringworm. If tincture of iodine be applied to the spots which have been treated as above, first with the spirits of turpentine and then washed with carbolic acid soap and water, it finds its way down into the epithelial structures, and into the hair-follicles, following the course which the spirits of turpentine has taken. It is of no use to apply watery solutions of germicides until the sebaceous or greasy matter of the scalp has been first removed.

In some severe cases I have used a solution of iodine in turpentine, ten grains to the ounce, instead of the tincture of iodine, after the head has been washed and cleaned; but in most cases the use of tincture of iodine, after the part has been acted on by spirits of turpentine as above described, is quite sufficient to destroy the disease.

Ringworm of other parts of the body may be treated with spirits of turpentine and tincture of iodine in the same way. One great advantage of this treatment is that it may be used on the head of the youngest child, and causes little or no distress at any time.—*Brit. Med. Jour.*

Burns and Scalds.—Dupuytren's classification of burns is into six degrees of severity:—1. Only inflammation of the skin. 2. Detachment of the epidermis and formation of blebs of various sizes. 3. Destruction of the cuticle and a portion only of the true skin. 4. Destruction of the true skin. 5 and 6. Muscles, tendons, nerve trunks, blood-vessels, and bones are involved. The following are the requisites which Dr. Woodward lays down for a good dressing for scalds and burns. It should—1st. Be comfortable to the patient. 2d. Diminish secretion from the affected part. 3d. Require to be renewed only at long intervals. 4th. Promote healing. The method of dressing adopted in the Bellevue hospital, New York, is as follows:—Supposing the burn is one of the second degree, the blebs are cut open with scissors and evacuated, the detached epidermis being carefully

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cut away. Whilst this is being done, the affected member should be irrigated with some antiseptic solution. He condemns bichloride of mercury dissolved in water (1-2000) as harmful in many cases, and regards carbolic solution as dangerous where the burnt surfaces are extensive and irritative in their action, causing a large secretion of serum. He recommends Turche's antiseptic fluid; this contains five parts of boracic acid, one part of salicylic acid, and 500 parts of water; it is not very irritant, and is perfectly effective. He regards it as the best solution for the purpose. Having thoroughly cleansed and rendered the burned region as aseptic as possible, a layer of subnitrate of bismuth, thick enough to thoroughly protect the part, is dusted upon it. Over this, four or five thicknesses of carbolised or bichloride gauze should be wrapped gently. Over all, some antiseptic cotton is placed in a thick layer, and bound on gently with a bandage. This dressing should remain perfectly sweet for a week or two. Should serum come through it after, a day or two more cotton and a bandage should be applied. The part is examined after a week or two, according to the size of the burn. Usually at the end of one week the burn is examined, and found healed throughout. If a change of dressing is required, it must be made under precautions similar to those observed in the first instance. In cases of the third and fourth degree of severity, after thorough cleansing of the wound from sloughs and other dead tissue, he recommends free dusting of the tissue with boracic acid crystals, or covering it with boracic ointment (℥j to ℧j) spread on antiseptic gauze. If the crystals are used, the part must be so treated, and in every instance the first or second application has been sufficient to check the spread of the disease. The only internal treatment was saline water or mixture.—*Dr. Schallenberger, in Phil. Med. News, April 5.*

Acne.—*Internal Remedies.*—Dr. Piffard, an American dermatologist, considers that, in the treatment of acne, internal measures are more important than external applications. For the common form (*acne vulgaris*), he says that the sulphide of calcium, given in small doses, is the most trustworthy agent that we possess. Next in usefulness he ranks the bromide of arsenic, which should be given in doses of from the $\frac{1}{100}$ to $\frac{1}{50}$ of a grain. It is best administered in alcoholic solution, well diluted. For a local application in acute cases, he recommends an ointment of belladonna; and in subacute and chronic, green soap or some murcurial ointment.—*Canada Med. and Surg. Jour.*

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Surgery.

Edited by G. FRANK LYDSTON, M.D., 125 State St.

Hydatid Tumors in the Brain.—By the term hydatid tumors in the brain, we mean the intra-cranial occurrence of either the echinococcus or the cysticercus cellulosæ in man. The former is the embryo of the tænia echinococcus, which has never been known to attain maturity except in the dog. The latter is the embryo of the tænia solium, which is most frequently found in man, the hog, and the rabbit, but not unfrequently in the dog and the common rat; and has been known to exist in the ape, the bear, and the deer.

The history of these strange parasites is only traceable to the oblivion of the unknown; before the time of Aristotle they were known to be associated with hydatid tumors, and were so regarded by Hippocrates; although it was left for Pallas to describe the echinococcus as a separate parasite in 1766, and for Goze to observe the same of the cysticercus in 1784.

The Mosaic law, which denounced as unclean all those animals which split the hoof and did not chew the cud, or those which chew the cud and did not split the hoof, was undoubtedly based on the existence of these parasites, for it is a well-known fact that the hog, and a species of hare common in the east, were particularly rife with the disease produced by these parasites. Nor were all the animals considered clean by the Mosaic law even free from this loathsome disease; for we find, on referring to the older works on sheep husbandry, the same disease treated of, under the synonyms of "turnstick," "sturdy," and "staggers," and more recently as "hydatid polycephalis cerebrais;" which proved to be very fatal in the flocks where it prevailed, and was described as a many-headed hydatid, each of which was mounted with a disk of sharp hooklets. The development of these parasites from the tape-worm through all their multiple metamorphoses until again a tape-worm was for a long time enshrouded in mystery; and it was not until comparatively recently that all the links in the chain were finally united.

In order that our subject proper may be better understood, we will give but a brief outline of the development of these tæniæ, which, during a certain stage of their development, may form cysts

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in the brain, or its membranes, of man. From Kuchenmeister, the eminent German authority, we have crystallized the following:

Division A.—Tænia echinococus. 1. Is found only in the dog, has but four joints, the last of which contains the genital organs, and also the ripe eggs. 2. When these eggs find their way into the stomach of man they migrate, as soon as germination takes place, through the system and there develop the echinococus which first form the so-called mother, or brood cysts. 3. These mother or brood cysts may develop as follows: (*a.*) The scolices or heads, directly from the mother cysts, when they are called echinococus scoliciparíens, and is frequently known under the name of E. veterinorum, owing to its frequent occurrence in the domestic animals, and is distinguished from the fact of its having from 28 to 36 hooklets. (*b.*) The mother cysts may develop daughter cysts or even granddaughter cysts, and from either of these latter cysts may develop the scolices, in which case they are called the E. altriciparíens, and from their frequent occurrence in man they are also known as the E. hominis, and can be distinguished by the fact of their having from 46 to 52 hooklets. (*c.*) The mother cysts may develop scolices externally, as is generally the case in animals, and from this fact they have received the name of exogens. (*d.*) Or the mother cysts may develop scolices internally, as is most frequently the case in man, when they are termed endogens. (*e.*) Lastly, the mother cysts may not develop scolices at all, when they are known as acephalocysts.

When these cysts or their scolices find their way into the stomach of the dog they develop into the tænia echinococcus; but should they find their way into the stomach of any other animal they will not reach maturity; although the embryo in the form of hydatid cysts will develop in man, as well as others of the animal kingdom; and will live in this embryonic state for years, or until it destroys the life of its host, yet it has only been known to reach maturity when eaten by the dog.

Division B.—Tænia solium. 1. It is found in man and the hog; and when matured gives off proglottides or the so-called joints, which, like the last segment of the tape-worm of the dog, contains the genital organs and the matured eggs. 2. These entire segments, or only a part of the eggs, may find their way into the stomach, from which, in an embryonic state, they migrate into the system, and

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there develop into the cysticercus cellulosæ, which passes through a series of metamorphoses similar to that of the echinococcus.

The so-called "measly" pork owes its peculiarities to the presence of these cysticerci, which, when eaten by man or other animals, will develop into a tænia solium, or tape-worm. Although we have two distinct species of tænia which give rise to hydatid tumors, and furnish a wide field for study, yet we do not think a special study of either, except so far as they interest us clinically, is within the province of this paper; and would respectfully refer those who care to look up the subject in detail, to Kuchenmeister or Leuckart. From a clinical standpoint it matters but little which species is producing the intrusion on the economy, the results to the patients are the same.

It is true, as a rule, that the cysts or hydatid tumors produced by the echinococcus are larger than those produced by the cysticerci, yet the latter make up for the deficiency in size by multiplicity in numbers. When hydatid tumors are opened and their contents examined with the microscope they may be found to contain complete scolices or just the scattered hooklets of broken and incomplete heads. When scolices cannot be found free in the liquid of the cyst, they may be found by examining the brood capsule, or lining membrane of the same, except in the case of acephalocysts, when no scolices or isolated hooklets can be found. These hydatid tumors contain a pale straw-colored fluid which usually contains no albumen, is freely charged with chloride of sodium, and contains a liberal quantity of succinic acid, which is not unfrequently found combined with lime or soda; also, traces of grape sugar, together with other chemicals, are generally found present.

Hydatid cysts of one or the other of these tænia have been found in almost all parts of the human economy, but especially in the liver, the cellular tissue, the brain, the spinal cord, the eye, the spleen, the lungs, kidney, supra-renal capsules, heart, and even in the osseous system.

Kuchenmeister, who collected 88 cases of cysticercus of the brain, found the cysts 49 times in the membranes, 6 of which were on the dura mater, 11 on the arachnoid, 23 on the pia mater, and 9 on the choroid plexus. Fifty-nine on the surface of the cerebrum, 41 in the cortical subtance, 19 in the white substance, 18 in the ventricles and aqueduct, 17 in the corporo striata and anterior commissure, 15 in

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the optic thalami and gray commissure, 4 in the corpora quadrigemina and the pineal gland, twice each in the trigona olfactorio, corpus callosum and medulla oblongata, once in the olivary body, and 18 times in the cerebellum. In the above, 18 per cent. were without any symptoms, in 6 they were only trifling, in 5 epilepsy alone was present, in 4 epilepsy with mental debility, in 15 epilepsy with paralytic symptoms, in 24 insanity without epilepsy, of which 7 were without motor or sensory disturbances, 17 had lameness, cramps, hemiplegia, paralysis and muscular twitchings, while out of all only 24 had epilepsy.

The size and growth of these hydatid tumors varies according to the space afforded them for development. It seems that their size depends more on the pliability of the tissues, rather than the quantity and quality of the nourishment furnished. The danger attending the presence of these hydatid tumors depends very much on their location and size. When they occur in the subcutaneous cellular tissue it is not attended with any great danger. I know of a young man who is under the care of my friend Dr. J. W. Craig, in whom they can be counted by the hundreds, notwithstanding the doctor has cut out several scores already, and yet the young man is apparently in good health. When they occur in the muscular tissue they become more and more injurious in proportion to their depth and the importance of the structures involved. Their occurrence in the anterior chamber of the eye may not occasion any grave symptoms, but when they occur in the posterior chamber, the vitreous, the retina, or under the retina, as observed by Sommering, Schott, von Graefe, Mackenzie, Baum, Esthlin Sickel, and others, they produce the most serious trouble. When they locate themselves in the brain or its membranes, they occasion a multitude of symptoms, which are modified by their location, as will be best observed in the cases I am about to report in this paper, and which, it will be readidy observed, renders the diagnosis exceedingly difficult and obscure.

Case I.—Dr. B., aged 46, a large, strong, hearty man, who was engaged as a traveling doctor, was taken ill in the summer of 1880; at first was easily fatigued, mentally and physically, but able to be up and around and practice his profession, which was soon followed with general malaise, which gradually grew worse until he had lost all inclination for business; this was followed by gradually increasing vertigo, could not sit upright long at a time, which became so bad as

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to almost disable him from walking across the room, or sitting up at all; when he attempted to walk would pitch forward on the face. As the disease grew worse he was taken with vomiting, with or without food, which assumed a reflex character. From the first there was a constant tendency for the head to drop forward, and toward the last, when not lying down, would sit with the head dropped forward, which tendency manifested itself even when lying down. He was extremely nervous, and toward the last his appetite, which had gradually failed him from the first, failed entirely, except that he had an incessant desire to drink milk, which was immediately vomited after entering the stomach. The bowels were regular and the urine normal. There was a gradually increasing stupor, with some mental aberration toward the last, which continued, together with an increase of all the other symptoms, until the patient died from collapse March 3d, 1881. The post-mortem revealed sclerosis of the gray portion of the brain, with softening in the right cerebellum and in both ventricles. In the right lateral ventrical was found a hydatid tumor the size of the first joint of a man's thumb, which was surrounded with some pus and considerable effusion.

Case II.—J. W. K., aged 28, a strong hearty laborer, was taken sick in the spring of 1879, with pain in the left side. No difficulty with the hearing, complained of trouble from coughing with pain in the chest; partial paralysis of right arm. In February, 1881, had a similar attack; also one in 1882, which was followed with another in December, 1883, when he commenced to have an offensive discharge from the left nostril. In May (23d,) 1884, he was taken with a chill, followed with pain in the left side of the head. Had a troublesome cough of a nervous character; appetite good, which continued to the last, with no vomiting; bowels regular; no alteration of the temperature, but some nervous excitability of the pulse, which would often rise above or drop below the normal, and in a short time return to the normal again. Would often complain of a cold spot on the top or left side of his head. Was troubled at times with diplopia, and flashes of light in both eyes. Had been able to do manual labor, however, between each of the other attacks, and even up to commencement of this last attack, at which time he had an exaggeration of all the former symptoms excepting the paralysis; but more especially the pulmonary symptoms, which gave rise to coughing and dyspnœa, These symptoms increased until he died from general exhaustion June

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1st, 1884. Assisted by Dr. J. Harvey Craig I made a post-mortem five hours after death, and found a large hydatid tumor located in the left lateral ventricle, nearly as large as a hulled white walnut. There was considerable effusion, with softening and destruction of the brain substance on the left side, and thickening of the membranes of the cerebellum and spinal cord, with here and there spots entirely destroyed by softening. An examination of the rest of the body revealed nothing of an abnormal character.

CASE III.—O. H. B., aged 52, a strong, robust man, was accustomed to doing considerable mental and physical labor. Commenced complaining in the spring of 1882, with general debility accompanied with some dyspnœa and difficulty in deglutition, but had no trouble digesting his food after getting it swallowed; bowels were normal and urine natural at first, but contained some albumen toward the last. Was advised to take a trip for his health, but returned feeling worse; both the asthmatic symptoms and the difficulty in swallowing were much worse. His gait became unsteady and staggering, but no paralysis, and mind clear and no tendency to spasms. These symptoms gradually became worse until the patient died of exhaustion December 30, 1883. The post-mortem showed evidence of athoromatous degeneration of the cerebral arteries, more especially those in the circle of Willis, but little effusion. Two hydatid tumors were found in the right lateral ventricle, and three in the left lateral ventricle, varying in size from a grape down to that of a pea.

CASE IV.—Mrs. McS., aged 57, an ordinarily healthy female, had been married and raised a family, but was now a widow; had "changed life" at the age of 50. Had not been feeling well for some time, but commenced to grow worse in 1877, when she was very much debilitated; some mental aberration, among the first of which was that of imagining she smelt the fumes of a tobacco pipe. She next became contrary in almost everything, which was the more noticeable on account of her previously agreeable disposition; she imagined every person wanted to poison her. Her general lassitude increased, her gait became staggery, and she soon lost all ability to maintain the upright position, and when attempted, had a tendency to pitch forward; complained constantly of a cold spot on the top of the head. She had a constantly sick stomach, with vomiting only toward the last; a constant desire to urinate, was very thirsty and drank a great deal; had some fever at times in the latter part of her illness; toward the

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last the pain in the head subsided; had great difficulty in deglutition, very great dyspnœa, some paralysis on the the right side. A week before she died became blind and deaf, with complete aphasia, and finally went into a comatose condition and died March 12th, 1884. The post-mortem revealed two hydatids in the right and three in the left ventricle, with marked cerebral effusion and general softening of the entire brain substance.

For the first, third and fourth cases I am indebted to my personal friend and fellow-townsman, Dr. J. W. Craig, although the writer was present at the necropsies of all excepting case number III, but had the pleasure and profit of examining the tumors removed in that case.

In our opinion, the first and second cases were produced by the ecchinococcus, while the third and fourth were the result of the cysticercus cellulosa.

By permission I quote from a private letter received from Prof. Wm. Pepper, of the University of Pennsylvania, in which he says: "I have met with two cases, but unfortunately, the clinical records are so imperfect that I shall not publish them. The autopsies were, however, carefully performed. There was one hydatid in the retina in one case, with a cyst in the right anterior lobe of the brain. In the other the cysts were found on the left side of the base. They were both hospital cases, and no record could be obtained as to their previous history. The one is undoubted as to its character, while in the other it is believed that the cysts were hydatid from their general gross appearance."

For a number of the following synopses of interesting cases of hydatids of the brain and spinal cord, I am not only indebted to my personal friend, Dr. N. Senn, of Milwaukee, for kind assistance in collecting them, but also for their translation; also to Dr. Robert Herdegen, of Milwaukee, for his assistance in the same.

Dr. J. Klob reports two cases of cysticercus cellulosæ in the brain, in the *Vienna Weekly*, Nos. 8 and 9, 1867. The first case was that of a man aged 54, who two years previously suffered from rheumatic pains in the lower extremities. For some time gradual loss of memory. Pupils somewhat dilated; speech slow, but plain; difficulty in hearing; movements of the upper extremities slow and with effort; toward the last the patient was troubled with incontinence of urine, lower extremities paralyzed. A post-mortem examination showed

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the dura mater to be tense, brain swollen, left hemisphere of the brain somewhat larger than the right. On opening the left lateral ventricle a large cyst with delicate walls escaped, which contained a clear, watery fluid. The cyst was as large as a medium-sized apple. From the under surface a pedicle of gray color was given off, to which two smaller cysts were attached. A peculiar pigment was observed, arranged symmetrically, in the centre of which were found the hooklets of the cysticercus.

The second case was a woman 43 years of age, who after intense fright suffered from severe headache, and a few days later was seized with convulsions. These convulsions appeared at short intervals, and assumed an epileptiform character. The convulsive movements affected mostly the left side of the body. On the eleventh day of illness she died, death being preceded by collapse and stupor. On post-mortem examination the dura-mater was found tense. In the pia mater, over the right cerebrum, were found chalky nodules, which were identified as cysticerci which had undergone calcification. On the lateral surface two recent cysticerci were found. In the posterior portion of the right side of the brain a closed cavity the size of a walnut was found, which communicated with another cavity the size of a pea by a narrow channel. At the point where both of these cavities joined was found a calcified cysticercus.

Drs. W. and G. Markle report a case of cysticercus cellulosa in the cerebellum in the German Archives of Clinical Medicine, vol. iii, p. 297, in which the patient was a strong boy of 13, who was taken ill with severe pain and stiffness of extensor muscles of the neck, which abated slowly and imperfectly. After a few months severe attacks of headache were complained of, which were accompanied at times by vomiting. These severe attacks were succeeded by sleep resembling stupor. Death occurred suddenly. The post-mortem revealed in the left lobe of the cerebellum a tumor the size of a hazelnut, with a resistant yellow nucleus. The entire white substance of the cerebellum was softened and gelatinous. The swelling was surrounded by a layer of pus 1 mm. in thickness. The tumor consisted of a cyst, which contained detritus, in the centre of which a well-preserved cysticercus was found.

A similar case is reported by G. Markle, in the person of a boy 10½ years old, previously in robust health, who was taken ill with headache and vomiting. In one of these attacks of headache he be-

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came restless and delirious, which was followed by unconsciousness, stupor and death. At the necropsy, a cyst the size of a cherry was found in the infundibulum, which proved to be a cysticercus cellulosa. The gyri of the brain were flattened, the consistency of the white substance was firm.

Dr. Marks, in writing of the echinococcus in the brain (Virchow in Hirsch's yearly report, 1873, vol. i, p. 640) reports a case of echinococcus in the brain which is of interest on account of its location in the left temporal lobe of the brain. The patient, who was 40 years of age, had had an attack of dizziness during the month of December, 1871 In July, 1873, he was seized with another attack, which was followed with facial paralysis of the right side, complete paralysis of the left upper extremity, partial paralysis of the left lower extremity. Sensation in both right arm and leg diminished. His condition, both mentally and physically, gradually became worse, especially the aphasia. He at last passed into a stupor, had incontinence of urine, followed by death. The autopsy showed great tensity of the dura mater, the convolutions of the cerebrum were flattened, but more on the left than on the right side. On the outer side of the left temporal lobe a green discolored spot the size of a dollar was found, below which, at the depth of 2 mm., an echinococcus cyst the size of a fist was found, which contained a clear fluid. The cyst could be removed with ease from the substance of the brain. The right half of the pons was flattened, while the remaining portions of the brain were not materially changed.

Griesinger, who has collected over 70 cases of these parasitic affections of the brain, 54 of which he describes minutely, 21 of which were his own cases, found their occurrence in the spine very rare, of which Dr. Otto Hebald reports two very interesting cases, which are recorded in vol. xv, No. 3, p. 812, of the *Archiv fur Psychiatrie*, Berlin, 1884; for the translation of this, from which I only give a synopsis, I am indebted to Dr. Henry Ruess. of Mansfield, Ohio:

The first patient was an idiotic female, aged 63, of healthy parentage, but who had an idiotic half-sister. Early in life she became hysterical. Seven years ago was troubled with hallucinations, a year later was taken with epileptic convulsions, which occurred frequently, together with vomiting, two years later became blind, with partial paralysis, and perverted sensibility, difficult articulation, general depression, followed by death. The autopsy revealed cysticerci under

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the pia mater of the spine and brain, also in the cortex of the latter. One was found free in the lateral ventricle, also one in the muscle of the heart, and under the pleura costalis.

In the same article he reports another case which occurred in a female aged 65, who was of an irritable disposition, especially during the menstrual period, who was taken ill in 1876, showing signs of brain irritation, with hallucinations in hearing. At times had attacks of religious exaltations, at others tore her hair, and at times was very destructive. After being removed into the asylum her symptoms grew worse, would inflict injuries upon herself and others; she was exceedingly filthy, would eat her own and others' fæces. In 1877, symptoms of pressure on the brain, with epileptic attacks, with unconscousness, had vomiting of green matter, slight paralytic symptoms in the right upper extremity. Her condition, with occasional short improvements, gradually grew worse, which was attended with difficult articulation. In 1879 partial and total blindness set in; from that time to 1881 and 1882 paralysis of lower extremities; toward the last, in 1883, had to be carried around. Epileptic attacks preceded her death, which occurred in the summer of 1883. The autopsy revealed cysticercus the whole extent of the dura spinalis as high as the first dorsal vertebra, also over the right anterior and lateral division of the medulla. Marked adhesions of the dura to the cranium. Scattered under the membranes and over the brain in both lateral ventricles were cysts of the cysticerci from the size of a pea to that of a bean, which were filled with a clear yellowish liquid. Also in the right posterior wall of the chest, under the pleura, were found four cysts about the size of a bean, also one under the left pleura costalis. The writer observed that only those in the ventricles were well developed, the rest were imperfectly developed, and that those in the substance of the brain were smaller, and had a tougher capsule. A few reached into the white substance of the brain, but not a single one was found there alone; the majority being in the cortical substance of the brain, in different parts of it. After making a careful analysis, the author arrives at the conclusion that the case was primarily one of insanity, which led to the eating of fæces, by which she became infected with the cysticerci, which developed a new train of symptoms still later, which subsequently produced death.

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Ulrich, in abstract in *Virchow*, 1872, No. 2, p. 16, reports a case of cysticercus in the brain and spine both, in an insane person. Regarding this case, he says the insanity was not caused by the cysticercus, but the cysticercus was the result of the extremely filthy habits of the person.

Yates—abstract in *Virchow*, 1870, No. 2, p. 60, reports a case of a young man who died at the age of 21, who was under his care for two years previous to his death, and complained of headache, weakness of legs, hemiplegia, light delirium and stupor, followed by death. Autopsy revealed a hydatid tumor the size of an ostrich egg in the left hemisphere of the cerebrum. The patient died suddenly, but notwithstanding his stupidity, he was able to answer questions intelligently up to the time of his death.

Sutherland—in *Virchow*, 1873, No. 2, p. 67, reports the occurrence of an echinococcus between the chiasm and pons, with compression of the two oculomotors, and destruction of the ventricles. His symptoms were intense headache, frequent vomiting, tinnitus aurium, deafness, and impaired vision.

Schlott—in *Virchow*, 1873, No. 2, p. 68, reports a case occurring in a former soldier, who took sick with frequent fits of giddiness, headache, nausea, and heaviness of his limbs, tongue blue and swollen, oscillations before the eyes, diplopia, staggering gait. His bodily and mental capabilities grew weaker, first vomiting and regurgitation, afterward would swallow with great avidity. Spontaneous discharge of fæces and urine, his language became stammering, choreic movements, subsultus tendinum, and finally died with pulmonary œdema. The autopsy revealed numberless cysticerci, from the size of a pin-head to that of a pea, in the dura over the base of the brain, as well as in the dura of the cerebrum, in the substance of the cerebrum and cerebellum, and also on the surface of the same, and in the ventricles and in the great ganglions, besides, they were even found in the muscles throughout the body.

Westphal—in *Virchow*, 1873, vol. 2, p. 68, reports an interesting case, with recovery, of echinococcus observed in the Charite, in Berlin, in a young man aged 17. The symptoms were headache, nausea, right exophthalmus, and protrusion of the right temporal bone, hemiplegia on the left side. These symptoms came on step by step, with exacerbations and remissions. The protrusion of the right parietal region became large, extending to the vertex. In four weeks

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after he entered the hospital, by the finger one could feel a perforation of the bone about an inch above the outer angle of the right eye; four days later there was another perforation near the first one. By and by, from these openings a fluctuating tumor appeared under the skin, and the tumor was diagnosticated echinococcus. An exploratory puncture failed, and an incision was made, which soon discharged about ninety cysts. Ten days later, by blowing his nose there came out of the left nostril a large and two smaller cysts. When the patient left the hospital a few weeks later, he was free from headache and hemiplegia, but the circumference of the right side was three inches larger than the left, and the exophthalmus still continued, with blindness. The openings in the bones still existed, the pulse varied from 90 to 150, with a normal temperature.

Eichorst, vol. II, p. 708, says the echinococcus usually consists of but one cyst, seldom multiple, but in the case of Espinosa there were fifty-two cysts under the arachnoid membrane.

The frequency of this disease depends on at least three factors: 1. The prevalence of making dogs household pets, as in Iceland, where it is estimated by some writers that at least one-tenth of the population suffer from echinococci, which is undoubtedly due to this cause. 2. The eating of half-cooked "measly pork," which gives rise to numerous tape-worms, and they in turn to the cysticerci. 3. The filthy habits of many, together with the increase of population, which necessitates the close commingling of all classes.

Hydatid tumors are found to be more frequent in old persons than in young persons, although they may occur at any age, and are more apt to be found among the poorer members of the population than among those in affluent circumstances, but sex does not appear to make any difference as to their frequency. The tape-worm and its embryo may exist in the same person at the same time, or a tape-worm and the echinococcus may exist in the same subject at the same time, but a tænia echinococcus and its embryo never have been known to exist in man at the same time. The prognosis in this disease as a rule is unfavorable when it is intra-cranial; only a few such cases of recovery are on record.

The treatment of these cases is also very unsatisfactory so far as therapeutic remedies are concerned. The salts of mercury and iodide of potassium have been, however, liberally used, with a view of destroying them by their antiparasitic effects, as well as for their alterative vir-

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tues. Tr. of kamala, in doses of from thirty to forty drops three times a day, has been used freely with some reputation for good. Electricity has filled its place in the catalogue of remedies used in this malady with a questionable reputation.

When accessible the most positive benefits are derived from surgical interference, by which the cysts are emptied, by laying them open with the bistoury; and now that surgeons are beginning to deal with the brain, as with other parts of the human economy, and more and more liberties are taken with it annually, it is hoped that sufferers from this dreadful disease may find a source of relief ere long at the hands of the skillful surgeon.

Although this disease, except in Iceland, is comparatively rare, and perhaps more so in America than in continental Europe, yet Dr. Osler states, in regard to the echinococcus disease in America, that he has collected from various sources sixty-one cases. (See transactions of Canada Medical Association, 1882, p. 354.)

With the steady increase of our population, unless active preventive measures are inaugurated we must expect a corresponding increase in his disease, which will steal in on us as a thief in the night, and cause many a premature death, unless we remove the causes which favor its production and development, viz.: Dogs as household pets, the use of half-cooked unhealthy pork, together with all general unsanitary surroundings. —*R. Harvey Reed, M.D., in Jour. of Amer. Med. Association.*

Obstetrics and Gynecology.

Edited by E. P. MURDOCK, M.D., 179 South Sangamon St.

Puerperal Fever.—Who of us present here to-night cannot call to mind a case, after labor seemingly the most satisfactory, which from the second to the fourth day, seldom earlier, sometimes later, was unexpectedly changed into one of the gravest and most alarming, by a sudden and extreme rise of pulse and temperature, distention of the abdomen, tenderness in one or both iliac regions, cessation, partial or complete, of the lochia, with momentous head symptoms pointing plainly to the oncoming delirium, perhaps of the greatest consequence to the welfare of our patient, who, but a few days ago, full of hope and promise of well-doing, now lies prostrate under a cloud of com-

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plications, the septic nature of which is at the present time so intently occupying the careful study and consideration of our most thoughtful and learned physicians?

Who can with such a case, point out, or lay his finger upon the starting place and say, here is the cause, or there resides the source and fountain-head of all this trouble? When we take into consideration the greatly altered blood state of the parturient female brought about by the wonderful course or operation of building up within the body of the mother another life, resulting in the physiological increase of fibrin, white corpuscles, and water, with a corresponding decrease of red corpuscles and a high state of nervous excitability and the astonishing amount of absorption and excretion which must rapidly go on after delivery, can we wonder that at times there may be a lost balance between these two latter functions, and that the retention within her system of dead or effete material, which should have found a rapid exit through the excretory organs, will set up serious constitutional irritation?

We all know only too well the horrible results of this lost balance between secretion and excretion even in natural fluids, such as that of a joint, the pleura, the tunica vaginalis, or even the pent up menstrual fluid in a virgin uterus; how by their presence rapid changes are brought about, suppuration established, and, by the severe impressions thus made upon the blood, we have systemic disturbances of the most alarming kind and life itself destroyed. Can we wonder when we recollect the well-known influence of emotions upon secretion and excretion, that our patient may be thus profoundly impressed and that in some cases this alone may be the most conspicuous, if not the sole cause of her fever? Or when owing to local or other predisposing conditions, the economy has all it can do to resist the threatened trouble, this disturbance through the nervous centers may be a sufficient exciting cause to disturb the balance and check the excretions for the time entirely. Here then we have as a result a disturbed system, quick pulse, increased temperature, wakeful nights, coated tongue, later on disturbance of the digestive organs, swollen belly, a scanty and offensive discharge from the womb, and in short a fever, which during the puerperal state, may be, and is, properly diagnosed puerperal fever—puerperal septicemia if you like—but it is one of those cases wherein the patient herself has furnished the toxic element from her own system for the establishment of the malady. Take

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for illustration another case, when, owing to severe and prolonged labor, the soft parts from the neck of the uterus down to the vulva have been bruised, lacerated and torn, the mucous tract and the submucous connective tissue contused and perhaps sloughing in patches here and there, we have as a result, a local inflammation with all the products of such inflammatory action, ready to be taken up and carried into a circulation already overburdened and taxed by effete and useless debris. Now to neglect this local injury and allow these inflammatory exudates to become pent up in the cavity of the womb and in the vaginal canal and through the torn lymphatic and other absorbent vessels to continuously pour their poison into the general circulation, how long will it be until the excretory organs become overpowered, the balance lost, the blood poisoned beyond recovery, and the patient killed? Does any gentleman here recall such a case and such condition of things from his own private practice, and does it require a Thomas to tell him that if he had scrubbed the ceiling, removed the draping from the window, taken up the carpet, and cleaned his obstetric finger nail, that such precautions would have prevented this case of fever? So I am brought to the consideration of the theory of hetero-infection, or infection from without. This theory holds that the disease is preventable, and says that its occurrence is on account of not carrying out certain rules laid down by the advocates of this doctrine that there are vegetable organisms floating in the surrounding atmosphere, specific baccilli which attach themselves to the appointments and furnishings of the lying-in room, that they lie in wait, hidden in obscure places, and are ever ready to pounce down upon and enter into the system through the genital orifice of any poor woman who may have the hardihood to bring forth her child and not keep her vulval aperture securely sealed with a wet carbolized rag—therefore her physician attending in this accouchment, and the nurse under him, must do thus and so, and if they dare to do otherwise then in the eye of the law they are culpable and guilty of gross neglect and heedless to the teachings of modern and good obstetric practice.

I have stated on another occasion, when this subject was being discussed in our society, that these rigid rules laid down by Dr. Thomas, were in some cases, nay, in most cases, such as the average physician has to deal with, impracticable, and not only that, but utterly useless.

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What good can come from disinfecting the walls of a room wherein a patient lies suffering from a case of auto-infection, where she has furnished, and continues to furnish, that toxic element from her sloughing vagina, or retained and decomposing bits of placenta? True the advocates of these extreme measures also tell us to pay attention to the vaginal tract, and to be vigilant in this quarter as well, but, if they admit that the cause resides here, wherefore the necessity for scrubbing the ceiling in a house which has been free from scarlet fever, small pox, and other zymotic diseases? I have been in the practice of my profession now some twenty years and in that time I have seen not a large number of puerperal fever cases, it is true, but I have seen sufficient already to convince me of one truth at least, and that is, that in my own individual experience, a large per cent. of my fever cases occurring in the puerperal state were due to local lesions, retained and pent up secretions, imprisoned and decomposing bits of placenta or shreds of membranes, and that the careful and gentle cleansing of these wounds, the opening of a closed os, and thorough draining and washing out of the uterine cavity, maintaining the bowels in a free and soluble condition, keeping the skin active, the kidneys at work, and above all, the avoidance of opium, has given such results that I am content to satisfy myself with these rational means, rather than to tie my hopes to the efficacy of such measures as have to do with fighting away bacteria from the walls of the bed-room.

There is a fever occurring in the puerperal state which undoubtedly has its origin from outside influences; I refer to that pyrexia which may be established by conveying to the genital tract, or by being inhaled or swallowed any of the necrotic poisons such as is obtained from dead or decaying animal matter, post-mortem filth or erysipelatous products, etc. Here we have the same effects to all intents and purposes that we might have from the poisoning of a stump from amputation of the thigh or arm after the third day, only modified of course by the altered blood state peculiar to the parturient woman as I stated in the first part of my paper, and also by the peculiar channels of entrance, when that entrance is gained via the parturient canal. Concerning those fevers which are the result of exposure to the eruptive zymotics, I would say that they are a simple repetition of the original disorder, modified it may be, by the peculiar changed blood state of the woman, and that this is true, we need only to refer to the

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numerous cases, where these fevers have produced in the non-parturient, the original disease such as scarlatina, measles, etc., or whatever it may have been in the first place.—*A. J. Russell in Denver Med. Times.*

Eye and Ear.

Edited by J. E. HARPER, M.D., 163 State St.

Maggots in External Auditory Meatus.—J. W., aged 17, came to my office June 20th, 1885, and gave the following history. While plowing corn on June 17th, a "blow-fly" entered the meatus auditorius externus of the left ear, and as he was a considerable distance from home and it caused him no great inconvenience he allowed it to remain there for over an hour before he went home and had it extracted. The next day he thought he felt something moving in his ear and used a warm milk injection which gave relief for a short time. The next day he used a turpentine and milk injection, but as this did not produce the desired effect and his ear became inflamed and caused him a great deal of pain he came to me for relief.

Upon examination I found the parts swollen and inflamed and no less than a dozen full-grown maggots in the meatus and on and around the tympanum. I removed the maggots with an ear-scoop, washed the ear with a five-per cent. solution of carbolized warm water and afterward poured a small quantity of carbolized olive oil into the ear, which had the desired effect of giving permanent relief.—*A. Wm. Vogt, M.D., Pleasant Mound, Ill.*

Editorial.

Anatomy Bill in Illinois.—The bill approved by the General Assembly June 26th, 1885, supersedes the law, previously in force, since 1874. The latter was defective, in that it permitted, but did not command, officials throughout the state to surrender the unclaimed pauper dead when proper application was made for them. For a year or two back this phraseology has been taken advantage of by a demagogical majority of the Cook County Board of Commissioners, and made it possible for them to prohibit the officials in their employ from delivering the bodies to the representatives of the medical colleges.

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Hence the colleges were seriously embarrassed by dearth of material, and some graves in private cemeteries were despoiled by "body-snatchers," who were bent upon earning an honest penny.

The present law—the outcome oi the combined efforts of all the demonstrators of anatomy in the city and the co-operation of medical men throughout the state—went into operation July 1st.

It commands state, county, town, and city officers, who have custody of unclaimed pauper dead, to surrender the same, free of charge, when proper application is made, to any medical college in the state, or any licensed practitioner—preference being given to the colleges—for use in promoting the science of medicine and surgery; provided, the applicant furnish a bond that the body shall be used only for the purpose indicated, and within the limits of the state. Provision is also made for the equitable distribution of the bodies, and a penalty of fine *or* imprisonment is attached to a refusal to surrender them.

The colleges are required to furnish them to students at a price not exceeding five dollars, and to bury decently, or cremate—under penalty of fine *or* imprisonment for failure or neglect—what remains of them after they have served the purpose for which they were yielded up.

Improper use of them, removal from the state, or any sort of trafficking in them, is defined as a misdemeanor, punishable by fine *and* imprisonment.

This law relieves teachers and students of anatomy in the state from the likelihood of embarrassment from expensiveness of material or scantiness of supply.

The law would make the privileges which it is intended to confer more secure if it determined the amount in which bond shall be required of those to whom bodies are delivered; for as it now stands, it is but waiting for another demagogical majority of small office-holders to say that bonds in the sum of a million dollars must be given for each and every dead body that is surrendered. Of course that would not embarrass a demonstrator of anatomy or a professor in a medical college, but it might be the means of preventing a very worthy *young* doctor from resuming the study of practical anatomy for as long as one or even two years.

Faculty Changes.—The College of Physicians and Surgeons, of this city, is to be congratulated upon the acquisition of Dr. Nicholas

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Senn, of Milwaukee, as the Professor of the Principles and Practice of Surgery, and of Dr. Christian Fenger, of Chicago, as the Professor of Clinical Surgery. These gentlemen are already known as among the most eminent surgeons of the country, and, indeed, their reputation is more than national. They are widely known as industrious, careful, and original investigators, and as thoughtful, accurate, and independent writers. Dr. Fenger has, until recently, been connected with the Chicago Medical College.

Miscellaneous.

How to Reach the Resorts of Colorado.—Colorado has become famous for its marvelous gold and silver production, for its picturesque scenery, and its delightful climate. Its mining towns and camps, its massive mountains, with their beautiful green-verdured valleys, lofty snow-capped peaks and awe-inspiring canons, together with its hot and cold mineral springs and baths, and its healthful climate, are attracting, in greater numbers each year, tourists, invalids, pleasure and business seekers from all parts of the world.

At each of the prominent Colorado resorts are spacious hotels so completely appointed that every appreciable comfort and luxury are bestowed upon their patrons.

The journey, from Chicago, Peoria or St. Louis to Denver (the great distributing point for Colorado), if made over the Burlington Route (C. B. & Q. R. R.), will be as pleasant and gratifying as it is possible for a railroad trip to be. It is the only line with its own track between the great lakes and the Rocky Mountains, and the only line running every day in the year through trains between Chicago, Peoria or St. Louis and Denver. It also runs through daily trains between Kansas City and Denver. These through trains are elegantly equipped with all the modern improvements, and ride you over a track that is as smooth and safe as a perfect road-bed, steel rails, iron bridges, interlocking switches and other devices, constructed in the most skillful and scientific manner, can make it. At all coupon ticket offices in the United States and Canada will be found on sale, during the tourist season, round-trip tickets, via this popular route, at low rates to Denver, Colorado Springs and Pueblo, Colorado. When ready to start, call on your home ticket agent or address Perceval Lowell, General Passenger Agent Burlington Route, Chicago, Illinois.

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Medicine.

Edited by WM. E. QUINE, M.D., 3151 Wabash Ave.

Peritonitis of Lower Abdomen.—Perityphlitis.—The general experience of pathological authorities shows that in a very considerable portion of fatal cases of inflammatory lesions in the ilio-cæcal region the *processus vermiformis* is in some way or other the source of the inflammation. In the minority there is inflammation of the cellular tissue lying chiefly behind the cæcum and ascending colon; and in such cases the peritoneum may escape implication, the abscess opening directly into the cæcum. And as in the case of the uterine organs the names perimetritis and parametritis have been devised to indicate the two modes of spreading of the inflammatory action referred to, so here the words perityphlitis and paratyphlitis have been employed; the former, however, embracing by far the greater number of cases, and being accordingly much the more familiar term in works on the subject. There is, moreover, a certain number of cases in which, though the inflammatory processes extend to the neighborhood of the cæcum, they do not originate there; as where a pelvic abscess (parametritis) burrows upward along the sheath of the psoas and iliacus muscles, or where a spinal or perinephric abscess burrows downward along the same sheath, and may end in forming a communication with the bowel, or by opening in the groin. In these cases the peritoneum usually remains exempt.

Now, in the cases which recover (and these are the large majority) it is often not possible to make an exact diagnosis of the seat of the

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primary lesion, and therefore it is vain to attempt to classify them as above; but in many or most of them the local peritonitis, extending from the right iliac fossa upward and inward, is the most prominent fact, and the name perityphlitis is applied without a too curious inquiry into the unknown origin of the lesion. The evidences of the inflammation are the pain, superficial or deep; tenderness on pressure, increased resistance, swelling, and dulness on percussion in the right iliac fossa; fever, often with repeated shiverings, and usually of a remittent type, which may go on, in protracted cases, into a kind of hectic; the bowels being more often than not constipated, but occasionally with intervals of diarrhœa. Vomiting is by no means a constant feature of such cases, but is sometimes pretty obstinate. Indeed, I have known the vomiting and constipation together such as to raise serious questions as to the existence of a mechanical obstruction or invagination of the bowel; but usually it is not so. In well-marked cases, the dense semi-solid feeling of impaction extends quite down to the pelvis: in others, towards the middle line, and sometimes even above the umbilicus; and, in the female sex, it may be only after careful examination of the pelvic organs that such cases can be distinguished from peritonitis of pelvic origin. Occasionally, and especially when it is inexpedient to make such examination, owing to the patient being unmarried, or to the rapid recovery, it remains a doubtful question to the last. I have seen several such cases in female children who all made good recoveries; and although these cases passed for perityphlitis, I am by no means sure of the pathology of them even now.

The most important clinical fact, however, to keep in view in dealing with such cases, is that a large proportion of them do, in fact, recover more or less completely, and after a longer or shorter period of careful management. This favorable prognosis is not commonly set forth, at all events so as to have impressed my own mind, in the various monographs on typhlitis and perityphlitis; perhaps owing to the fatal cases, and those submitted to post-mortem examination, being chiefly accumulated in medical literature, and thus becoming unduly prominent. In one very admirable memoir, however, I find the view now presented fully more strongly asserted than I should have been disposed to put it, even apart from the evidence in the cases above noticed. "I believe," writes the late Dr. Hilton Fagge, "that even when acute peritonitis is set up by ulceration of the cæcal appendix,

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the disease, if properly treated, is infinitely less dangerous than is supposed. I have never myself seen a case of this kind terminate in death, when its nature was correctly diagnosed, and when no purgatives nor enemata were allowed to be given. Nor of late years have any fatal cases occurred in the hospital (Guy's), except a few cases in which death occurred very shortly after admission. I have, therefore, been accustomed to give a favorable, though guarded, prognosis in cases of typhlitis, even when symptoms of diffused peritonitis are present. It may, of course, be said that the very fact that one can make an exact diagnosis proves that the disease is not running on to a fatal termination within the first few hours, and that the signs of the general inflammation do not preponderate very greatly over those of the local mischief; and I am ready to admit that there may be cases of sloughing of the appendix which are necessarily fatal. But, as I have shown, the differences in cases of typhlitis appear to to be differences of degree, and not all of kind; and I believe I am justified in saying that when this disease is skilfully treated it scarcely ever terminates otherwise than in the recovery of the patient."

Dr. Fagge further argues that there is no good reason to suppose (as has been supposed) that such cases, when they end in recovery, "differ essentially from cases of perforation of the appendix," which he regards as "really always the starting-point of the inflammation." He alludes to three cases in which it was pathologically determined that perforation was the cause of an attack which had virtually ended in recovery, when either a new attack of perityphlitis, or an intercurrent disease, attacked and carried off the patient. The most important of these cases is the following:—"A patient suffering from chronic pleurisy was attacked with pain in the right iliac fossa, and the other symptoms which I have just mentioned; a firm tumor, dull on percussion, could be felt in the right iliac fossa. Under careful management, the abdominal disease subsided, but pneumothorax occurred, and of this he died a few days afterward. The cæcum was closely adherent, a small collection of purulent matter surrounded the vermiform appendix. This was perforated at its extremity, and outside it lay a a small mass of hardened fæces."

I have already conceded that it is often impossible, clinically (in cases which end in recovery), to be sure of the exact seat and nature of the original lesion; and to this extent I am disposed to think that the weighty and striking sentences above quoted, from a great master

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of clinical and pathological investigation recently removed from us, may require some qualification. But the words of a man like Hilton Fagge must be taken as implying not only strong conviction, but conviction founded on an amount of closely observed fact, which is perhaps not fully brought out in the details of the memoir itself. There are many circumstances tending to the belief that peritonitis even from perforation of the small intestine is not so absolutely desperate a case as it has been frequently represented; and we have already seen that peritonitis of considerable severity and diffusion, arising from pelvic causes, admits of resolution, in many instances, with a completeness and rapidity that it is not easy, pathologically, to explain. The vermiform appendix is placed so as to offer the most favorable conditions possible for the isolation and limitation of the results of an ulcerative lesion, or even of a perforation; but it is not necessary to suppose that in most, or all, of these cases actual perforation occurs, if we only accept the idea that an ulcerative or other lesion tending to perforation is usually forestalled, as it were, by reparative processes which may often tend to prevent the threatened fatal rupture. In such processes, adhesive peritonitis, I believe, plays a principal part, and it is only a question of degree whether the extension and the character of the peritonitis are such as accurately to fulfill this, its conservative work in the organism, or such as to become more or less of a disease and a danger *per se*. At all events, there seems no escape from the conclusion that in some cases, at least (such as the one above quoted), even perforation of the vermiform appendix may be followed, or accompained, by what nearly amounts to a complete recovery, through adhesion of it to the surrounding parts.

Dr. Fagge further points out that "typhlitis often recurs again and again at intervals of a few weeks. It is also exceedingly apt to relapse during convalscence if the patient is allowed to commit any discretion." This statement I can fully confirm, and the importance of it, from a practical point of view, in connection with the preceding observations, need not be more particularly pointed out. The treatment of all such cases should be conducted on the same principles (mutatis mutandis) as in peritonitis of pelvic origin. Rest of the parts, absolute if possible, is the main indication of treatment, and this, in the case of the cæcum or vermiform appendix, implies, of course, abstinence from the use of purgatives, and not unfrequently, also, the administration of opium, and the limitation of the diet.

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Enemata, if employed at all, should be only such as to empty the rectum; but, on the principle that a lower bowel loaded with fæces is more open to strain than one cleared out by warm water in moderate quantity, I am not sure that I am prepared to accept without some qualification Dr. Fagge's conclusion that enemata, as well as purgatives, are to be entirely proscribed as a first condition of safety. It is perhaps necessary, however, to protest against Eichhorst's special recommendation of large cold water enemata three or four times a day in what may chance to be regarded as typhlitis stercoralis. I cannot say that I have had such experience as would induce me to pronounce this an entirely distinct form of disease; and if, on the other hand, the constipation, which often attends a case of inflammatory swelling in the iliac fossa, is not to be taken as the cause, but as the result, of the inflammation, usually, if not always, associated with ulceration of the vermiform appendix, a treatment founded on mere emptying the lower bowel, mechanically or otherwise, cannot be expected to be successful. A liquid diet, at first exclusively employed, and afterward only a very gradual introduction of the most completely digestible solid foods, will be rightly held to be imperative, owing to the same very obvious and paramount necessity of securing rest, as far as possible, to the whole intestinal tract, and especially to the cæcum. In cases where vomiting is obstinate and long-continued, I should not be restrained from clearing the rectum of its contents so far as to allow of nourishment and stimulants being given per anum; and morphia might in such case be used in considerable doses hypodermically. The patient should be rigidly kept in bed, and absolutely in the recumbent posture, till the tenderness and swelling are nearly if not quite gone; and, holding in view the risk of relapses, it is hardly possible to insist too much upon great care in this respect. The only local treatment I am disposed to recommend is the use of fomentations (medicated or not); poultices (if not too heavy): sometimes, if there is much distension, or if the fever is very high, the local application of cold for short periods by iced cloths; and, in more chronic cases the painting of iodine tincture, or liniment.—*W. T. Gairdner, M.D., LL.D., in Med. Times and Gaz.*

On Perforation of the Appendix Vermiformis.—There are some affections that occur so rarely that only a few instances fall within the observation of any practitioner, and they are consequently apt to be overlooked or confounded with other maladies of more frequent occurence,

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whilst the rules for their detection and treatment are necessarily vague or imperfect. It is some disorders of this kind that I would from time to time invite you to study with me, examining the symptoms they have presented during life, and, in such as have proved fatal, the morbid conditions discovered after death.

I would first invite your attention to a disease of rare occurrence, which has only of late years attracted the attention of practitioners, and which often presents considerable difficulty in diagnosis—viz.; perforation of the vermiform appendage. Five cases of this kind have been admitted into the hospital during the past twelve months, and I have selected two that occurred in my wards as illustrations of the symptoms and course usually presented by the malady.

CASE 1.—A man, seventeen years of age, was admitted under my care on February 14th, 1884, complaining of great pain in the abdomen, accompanied by weakness, to such an extent he was scarcely able to stand. He was very thin, with a face expressive of severe suffering, the eyes were sunken, and the skin remarkably dark around. He referred the pain chiefly to the epigastric region, although it extended over the entire abdomen, which was tender upon the slightest pressure; he had frequent vomiting, and the bowels had been constipated during the whole period of his illness. The pulse was 108, very compressible; tongue much furred; respiration, 42; temperature, 99.8°. The abdomen was greatly distended and tympanitic, but the loins and flanks were not distended, and there was no visible movements of the intestines. The hypogastric region was dull on percussion; over the cæcum the note was less dull, and percussion upon this part gave rise to a gurgling sound. On examination by the rectum a mass could be discovered in front, which was smooth, and gave the impression of its consisting of several coils of intestine united together. He stated that he had always enjoyed good health until nine weeks ago, when he thought he had hurt himself by lifting a heavy roll of paper; since that time he had lost flesh, but had been free from pain, or any other symptom. Seven days ago he was suddenly attacked with severe pain of the epigastrium shortly after supper, and the pain had continued ever since, in spite of medical treatment. Perforation of the appendix was diagnosed, and he was ordered frequent and full doses of opium. During the next three days he seemed somewhat easier, the vomiting was less frequent, and the abdomen became less distended. The temperature sank on the sec-

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and day to the normal point, and on the two subsequent days it was 97° and 97.6°. The physical signs remained unaltered, excepting that there was more fullness over the region of the cæcum, but the pulse became gradually more feeble, and he died on the tenth day of his illness.

Post-mortem examination.—A considerable quantity of pus escaped when the abdomen was laid open, and the intestines were seen to be everywhere adherent to each other, pus being situated between the adjacent coils. The part where the gurgling had been elicited by percussion was occupied by a fold of small intestine, bent upon itself, filled with air and fluid, and lying upon the cæcum, whilst the tumor felt through the rectum proved to consist of some coils of intestine united together, and enclosing collections of pus, and adhering by recent lymph to the back of the bladder and the sides of the pelvis. There was also a considerable quantity of free pus in the pelvis. The appendix was extremely congested, the tip being of a purplish color and much thickened; its sides at the lower third were covered with pus and lymph, and a concretion was felt impacted in its upper third, whilst between this and the tip was an ulcerated opening. The cæcum itself was congested, and contained only a few small pieces of fæces and bits of gelatinous-looking matter.

Case 2.—In the second case little complaint was made of pain. Although the hypogastrium was tender on pressure and slightly swollen, it was comparatively dull on percussion; and percussion over the right iliac fossa elicited a gurgling sound, as of air and fluid. This case also proved fatal. At the post-mortem examination it was found that the small intestines were adherent to each other in the hypogastric region, with pus situated between the adjoining coils, whilst a collection of pus presented itself in the pelvis, walled in by recent lymph and coils of intestines adhering to each other. The vermiform appendage was perforated by an ulcer, which communicated with the abscess, but no concretion could be found. The part where the gurgling had been heard on percussion was occupied by a loop of small intestine, situated over the cæcum, and adherent by recent lymph to the adjoining parts.

Now, it is scarcely necessary for me to point out to any of you who have attentively listened to the narrative of these two cases how remarkably they differ, although in each there was the same lesion of the vermiform appendage, and the same local inflammation resulting

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from it. But in the former case general peritonitis had existed from the first, the symptoms were ushered in by sudden and intense pain, vomiting and constipation; whilst in the latter the inflammation was confined to the part at which it had commenced, and the pain was never severe. The patient was, in fact, unable to fix the date of the beginning of his illness, and severe diarrhœa was the prominent symptom. But what we shall hereafter find was of great importance, was that in the first case the disease occurred in a person previously healthy and resulted from the irritation set up by a concretion; whilst in the second it took place in one who was suffering from long-standing phthisis.

When this accident first attracted the attention of pathologists, it was remarked that the appendix often contained a foreign body, and the idea arose that this was the sole cause of the ulceration. Out of 125 cases which could be examined as regards this point, in fifty-five it is stated that either a concretion, a mass of fæces, or some other foreign body, was present; and it is fair to conclude that the numbers would have been larger if a sufficiently careful search had been practiced in them all; for as the contents of the appendix often drop into the pus surrounding the ulceration, it is easy to understand that a small concretion may frequently have been overlooked. The nature of the foreign body has varied, for, in forty-seven cases sufficiently detailed to allow of analysis, twenty-eight were concretions, fourteen consisted only of hardened fæces, and, in five others, substances such as seeds or shell were present. But why should a foreign body in this part set up such serious results, when we know that in many instances the appendix has been found on post-mortem examination to be occupied by shots, seeds, and even, as in a case lately observed here, by lumbrici, without any apparent ill results; and when we so constantly meet with concretions in the kidney and the gall-bladder without any manifestations of disease having arisen from their presence? I think in most cases the presence of a concretion by its irritation gives rise to ulceration, and the proximity of the part to the cæcum filled with decomposing materials tends to produce sloughing in what would be otherwise a mere abrasion of the mucous surface.

Most of the cases of ulcerated appendix in phthisical subjects occur at a later period of life than when it is due to the presence of concretions or catarrh, for out of those I have collected only one was below

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twenty years of age, seven were between twenty and forty, and three were above forty.

I have already mentioned the prevalent idea that the concretions so often found in the appendix are always the result of hardened fæces or of indigestible materials of the food, and if such were the case we should expect to find that most of the sufferers had been liable to constipation. Now, I have collected forty-three cases in which the previous state of health is recorded, and of these only three had been subject to a constipated state of the bowels. It is therefore evident that this theory derives but little support from facts. I should be more inclined to believe that the concretions are in most instances the result of an excessive secretion of the mucous membrane of the appendix arising from the stimulus afforded by an undue use of solid and indigestible food. This view derives support from the fact that of twenty-five cases in which a concretion was discovered twenty are described as having enjoyed robust health, and three had been delicate; whereas of eight in whom no concretion was discovered, only five had been robust and three delicate. The presence of a concretion produces no pain until catarrh or ulceration is excited, for out of twenty-five cases of concretion only two had previously complained of abdominal pain; whilst of eighteen in whom no concretion was recorded, five, or 30 per cent., had suffered in this way. I have before mentioned that injuries to the abdomen are supposed by some authors to give rise to ulceration of the appendix, and this derives some support from the fact that three cases out of eighteen in which no concretion was discovered referred their complaint to blows or strains. In four instances out of forty-three there was a history of a previous attack of typhlitis from which the patient had perfectly recovered; in two of these the patients died from peritonitis only, and in the remaining two both abscesses and peritonitis were discovered after death.—*Samuel Fenwick, M. D., in Lancet.*

Vaccino-Syphilis Experiment.—(Editorial in *British Med. Jour.*, May 13, 1884). With a desire to settle for himself the vexed question, whether vaccine lymph taken from a syphilitic person, if unmixed with the blood of the vaccinifer, does not contain syphilitic virus, and is incapable of imparting syphilis by its inoculation, Dr. Cory made, at intervals, four separate experiments upon himself with lymph derived from obviously syphilitic children. The last experiment was successful, and Dr. Cory had to endure all the pains and penalties

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of syphilitic inoculation. The committee appointed to investigate Dr. Cory's experiments, consisting of Drs. Bristowe, Humphrey, Ballard and Mr. Hutchinson, report that it is possible for syphilis to be communicated in vaccination from a vaccine vesicle on a syphilitic person, notwithstanding that the operation be performed with the utmost care to avoid the admixture of blood.

CHICAGO MEDICAL SOCIETY.

STATED MEETING, AUGUST 3RD, 1885.

PRES'T CHARLES T. PARKES, M.D., in the chair. DR. FRANKLIN H. MARTIN read a paper on the "Oleate of Manganese." He said: There is little doubt left in the minds of therapeutists in regard to the value of manganese in certain forms of menstrual trouble. The remedy, in the form of permanganate of potash, was first brought to the attention of the profession by Ringer and Murrell, of London, in the spring of 1883. They recommended the drug in functional amenorrœa. Soon after this he commenced experiments with the same preparations, and published the results in *The New York Medical Record*, Sept. 29, 1883. To his knowledge, that was the first that anything on the subject was published in this country.

In the course of his experiments, acting on the theory that the drug produced menstruation by stimulating the menstrual organs, he was induced to give the remedy in monorrhagia and metrorrhagia dependent upon an *atonic* condition of the organ. He found to his gratification that it acted equally well in these conditions, as in the opposite. He has also obtained good results from its administration in irregularities incident to approaching menopause. He has received very gratifying letters from many members of the profession throughout the country, who have used the drug in one or more of the conditions mentioned above, with good results.

Dr. THOMAS, of New York, says of the remedy: "I think it is the best emmenagogue which has yet been discovered."

Dr. ROBERTS BARTHOLOW not only recognizes its power as a remedial agent in amenorrhœa, but also considers it a general stimulant, making it equally efficacious in other menstrual difficulties dependent upon an *atonic* condition.

After publishing his second report on this subject, the author received a letter from Sydney Ringer, of London, in which he expressed

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his gratification at the result of his experiments, and in which he said: "Like you, I have found the permanganate most useful in atonic conditions," and further remarked, "I was quite prepared to learn that the permanganate is useful in menorrhagia."

Since there is no longer any doubt about the great value of this drug in the distressing menstrual difficulties, the next formidable problem for the therapeutist to solve is. "How shall it be administered? The permanganate of potash, the original preparation used for experiments and administration, in any form is liable to act as an irritant to the stomach. It has in many ingenious ways been made into pills, but as these pills must of necessity have for their basis keolin, or some other inorganic substance, the drug in this form is not satisfactorily absorbed. The compound tablets of Wyeth & Brothers, and other druggists, are objectionable, in many cases of irritable stomach, because the irritating undiluted drug comes in direct contact with its mucous membrane. On account of the many difficulties of administration, therefore, this valuable remedy has not met with the reception that is its due. Following the suggestion of Dr. LEWIS L. MCARTHUR, of this city, he succeeded in having an oleate of manganese prepared. This oleate was made for him by Edward Kreyssler, of the firm of Forsyth & Schmid, of Chicago. He says he is indebted to Mr. Kreyssler for the following statement of the *mode of preparation and of the physical and chemical properties of the oleate of manganese:* A solution of sulphate of manganese was made in distilled water, and to it a solution of sodium oleate was added. On mixing these two solutions gradually, and with constant stirring, a precipitate of oleate of manganese resulted. This precipitate, upon heating, changed to a putty-like mass. This was washed several times with warm distilled water, to remove the sodium sulphate, and the resulting mass was the pure oleate of manganese. It is of a light-gray color, having a pinkish hue, of a sweet musty taste and peculiar clay-like odor. It is sparingly soluble in alcohol, soluble in ether, chloroform, olive oil and oleic acid.

Method of Application.—He recommends that one drachm of a twenty per cent. solution of the oleate of manganese in oleic acid be applied to the abdomen of the patient, and its absorption promoted by friction with the hand.

In amenorrhœa it should be applied, if possible, every night for a week preceding the expected menstrual period, or at the time menstru-

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ation is due, and until it makes its appearance. In menorrhagia or metrorrhagia it should be applied in smaller quantities, every night, until the desired effect is produced.

Of about a dozen cases in which the oleate has been prescribed by him, but four had reported. The success in these four was all that could be wished. Three of the four were cases of *atonic amenorrhœa*, the fourth, irregularity due to approaching menopause.

In the discussion DR. ETHERIDGE thought much advance would be made in the use of drugs if we were more careful to discover in what conditions they were beneficial. He had found this remedy useful in cases of atonic amenorrhœa, with the uterus in its normal position. He had found the aqueous solution an eligible preparation, and had also used it in the form of a suppository.

DR. E. J. DOERING, said he had used this remedy in some cases of atonic amenorrhœa with good results. He asked the effect of the drug upon the pregnant uterus.

DR. PAOLI had used manganese somewhat for several years, in cases of menstrual disorder, with varying degrees of success. It was a useful remedy in many skin diseases. He had not used the oleate, and could not see how it acted upon the uterus, unless, possibly, by being applied at once after being freshly prepared.

DR. MARTIN closed the discussion by saying he had used the aqueous solution in very small doses, also had had the remedy put in dry papers and swallowed with a glass of water. He had never used it in the form of a suppository. Manganese has no effect on the pregnant uterus. The drug seems to act as a general stimulant to the uterus, causing it to perform its normal function. It might be absorbed as the oleate and so produce its effects.

"Does the Use of Tobacco Injure Sight?" Was the subject of a paper read by W. FRANKLIN COLEMAN, M.D. The question was answered affirmatively by the author.

In the discussion DR. PAOLI said while the excessive indulgence in tobacco might be harmful, the fact of its almost universal use and continued use in many cases for years resulted in no deleterious effects, would seem to show that its narcotic power, used in the ordinary way, was very slight. He had used tobacco for fifty-five years and felt no ill results. The Germans use large quantities of it, and do not suffer. This seemed to be a case of excess of zeal on the

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part of the ophthalmologists to discover a cause for amaurosis. We ought to be conservative on this point.

Dr. Coleman closed by saying that only in certain susceptible conditions was tobacco liable to cause disorders of vision. But that so few suffered was no proof that it had not this baneful influence when acting with other causes.

LACERATION OF THE CERVIX UTERI.

Dr. John Bartlett read a paper in which he said his object in addressing the Society was to suggest a way and a time in which laceration of the cervix uteri may be easily and certainly detected soon after its occurrence.

Directly after delivery, if the fingers be introduced deeply into the vagina up to the contracted os uteri internum, and then carried in any direction a little outwardly, the flabby and floating ring formed by the non-contracted cervix may be felt, as Guillemeau described it 300 years ago, "like a section of large intestine."

By very carefully following the entire circumference of this ring an existing rent may be discovered. But this examination is attended with some difficulties. The patient is exhausted with her labor, and fatigued with attentions, and just now, since "it is all over," longing for rest. She is impatient of, and perturbed by this *post factum* inquiry. Her state of mind, and possible expression of complaint, are apt to render an examination, which the physician cannot regard as absolutely necessary, less exact and thorough than it would be otherwise. And then, the soft and floating margins of the cervix have often somewhat of an intangible feel, if the expression be permitted, gliding past the fingers like a detached clot of blood, and occasionally, in some portion of their circumference, passing out of satisfactory reach.

On this account it is not surprising to hear an obstetrician say that he cannot tell whether the post-partum cervix is lacerated or not. The error of the accoucheurs who fail to recognize such a condition is, that they do not make their observation of the suspected cervix at the proper time. They examine the neck actually, as has just been done mentally—after the clearance of the uterus. The favorable moment for the examination—and that he said was the special point of his remarks—is just as the placenta is beginning to occupy and distend the cervix. The collar of flesh is not then floating and uncertain in feel, but stretched and expanded, forming a distinct ring,

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easily followed in its entire circumference. At this moment then, just as the cervical tube is being rendered tense by the placental mass, any laceration in it may be detected with ease and certainty.

DR. ETHERIDGE asked the author of the paper whether he had verified a case by speculum examination after discovering it in the way he had illustrated in his remarks.

DR. PARKES said he had great difficulty in detecting laceration after delivery, on account of the relaxed condition of the parts. He thought the suggestion of DR. BARTLETT as to the way to obviate this difficulty was a good one.

DR. DOERING inquired as to the size of lacerations he had found.

DR. BARTLETT concluded by saying that he had verified cases of laceration discovered in the manner proposed by him. The largest laceration he had found was one and-a-half inches in length, and the end of the little finger could be passed into it. In one case he encountered considerable hemorrhage from such a rent: and this may be the cause of continuous loss of blood when the os is well contracted.

DR. BARTLETT illustrated his remarks with earthen-ware models, turned by a potter, under his immediate direction.

Society then adjourned.

Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

Pilocarpine in Diabetes.—One-twentieth of a grain of pilocarpine combined with one grain of sulphate of potash, three times a day, has been found successful in a large number of cases of diabetes mellitus. The London *Medical Record* considers the value of this drug in the disease as established.

Chloral and Ammonium Bromide in Febrile Delirium.—These two agents are of great service in treatment of the delirium incidental to typhoid and eruptive fevers. The delirium frequently yields to fifteen or twenty grains of bromide of ammonium in divided doses during the day, with small doses of chloral at night.—*Dr. G. H. Hughes.*

Therapeutical Indications in Typhoid Fever.—There is no single or unique treatment of this fever. Prophylaxis can arrest its development and dissemination. Treatment should be symptomatic, and should be directed against the various morbid actions which arise in different cases.

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The fever should not be too energetically treated, unless the temperature rises significantly.

Quinine is the safest and the best antipyretic agent for internal administration.

The strength should be well supported from the very commencement.

The nervous phenomena should be combatted by hydrotherapeutic measures; cold baths reduce the fever, and have a tonic action on the nervous system.

The digestive organs should receive special attention.—*Dr. Aubert*, (*Montpelier*).

The Allgemeine Medicinische Central Zeitung says that Dr. Domingo Freire, of Rio de Janeiro, the discoverer of the bacillus of yellow fever, has met with surprising success in his inoculation experiments. Of nearly 1,000 persons inoculated by him, not one single case was severely attacked, and the very few that suffered had the fever in the mildest form possible.

Glycerine for Dry Tongue and Thirst.—Surgeon-Major S. K. Cotter, in a recent number of the *Indian Med. Gaz.*, relates the case of a patient suffering from enteric fever who was awakened every ten minutes by the dryness of his tongue, which was parched and covered with sordes. The tongue was painted with glycerine frequently, and the result was that at the first trial the patient slept almost comfortably, waking up about every two hours with the tongue feeling dry, but not really dry to the touch; after renewed application of the glycerine he at once slept again. Surgeon-Major Cotter does not attempt to decide whether it acts by increasing secretion from the mucous membrane, dissolving the sordes, or making an artificial coating. But, in whatever way it acts, its benefit is vouched for when the tongue is parched during any disease.

Medicines which Stimulate the Liver.—Podophyllin, in small doses, is a stimulant of the liver. During the increased secretion of bile, the percentage amount of the special bile solids is not diminished. If the dose be too large, the secretion of bile is not increased. It is a powerful intestinal irritant.

Euonymin is a powerful hepatic stimulant. It is not nearly so powerful an irritant of the intestines as podophyllin.

Sanguinarian is a powerful hepatic stimulant. It also stimulates the intestines, but not so powerfully as podophylin.

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Irisin is a powerful hepatic stimulant. It also stimulates the intestines, but not so powerfully as podophylin.

Leptandrin is a hepatic stimulant of moderate power. It is a feeble intestinal stimulant.

Colocynth is a powerful hepatic as well as intestinal stimulant. It renders the bile more watery, but increases the secretion of biliary matter.

Jalap is a powerful hepatic as well as intestinal stimulant.

Menispermin does not stimulate the liver. It slightly irritates the intestinal glands.

Baptisin is a hepatic, and also an intestinal stimulant of considerable power.

Phytolacin is a hepatic stimulant of considerable power. It also slightly stimulates the intestinal glands.

Hydrastin is a moderately powerful hepatic stimulant, and a feeble intestinal stimulant.

Juglandin is a moderately powerful hepatic and a mild intestinal stimulant.

Chloride of ammonium is credited with cholagogue properties, but it is questionable; nevertheless, it certainly stimulates the intestinal glands.

Calomel is a powerful purgative, but whether it stimulates the liver is still *sub judice.*

Corrosive sublimate is a potent hepatic stimulant, but acts feebly on the intestine.

Sulphate of potash is a powerful intestinal irritant, but its action on the liver is variable and unreliable.

Taraxacum is a feeble hepatic stimulant.

Dilute nitro-muriatic acid has a moderate stimulant action on the liver.

Boldo, bromide of potassium, nitrate of potash, and hard soap have each some stimulant action on the liver.

Class-Room Notes.—We clip the following from the *College and Clinical Record:*—As a strong solvent for urinary calculi, of the uric acid variety, Prof. Bartholow speaks highly of the tartraborate of potassium in doses of a scruple ter die, in water.

Prof. Da Costa, in functional indigestion, advises the following course of treatment:

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℞ Acidi nitro-muriatici..... ʒ iij
Vini pepsin..... ʒ ij
M. Sig.—A teaspoonful ter die, at meal time.

An excellent cold application is formed of the following (Prof. Gross):

℞ Potassii nitrati.....
Ammonii chlorid.....aa.. ʒ v
Aquæ..... ℥ j

A child five years old was shown to the class, by Prof. Bartholow, who had dyspepsia, with morning nausea and vomiting. It was given liq. potassii arsenitis, gtt. j, in water, ter die, after meals.

The early treatment of congenital syphilis, with Prof. Gross, consists entirely of inunctions of the ung. hydrarg. oleat., five per cent. When child is old enough, give mercury by stomach, and preferably the hydrarg. cum creta.

When a syphilitic patient cannot take potassium iodide, Prof. Gross gives,

℞ Tinct. iodi..... gtt. vj
Syrupi aurantii..... ʒ j
Aquæ.....q. s. ad.. ℥ j
M. Sig.—Ter die.

For dyspepsia Prof. Pancoast likes a combination as follows:

℞ Elix. pepsin. et bismuth..... ʒ ij
Ext. cinchonæ fld..... ʒ j
Elix. zingiberis..... ʒ j
M. Sig —Dessertspoonful at meal time.

As a tonic in broken-down individuals, Prof. Pancoast prescribes:

℞ Quininæ sulph..... gr. j
Ferri pyrophosphat..... gr. ij
Ext. ignat. amar..... gr. ½
Mix.—Ft. pil.

Prof. Gross recommends the following as a hair tonic:

℞ Tinct. cantharidis..... ʒ jss
Tinc. capsici..... gtt. xx
Glycerini..... ʒ ss
Aquæ cologniensis.....q. s.. ℥ vj

When constipation is limited to the gastric trouble, use:

℞ Pulv. rhei.....1 scruple
Quininæ sulph..... gr. x
M.—Div. mas. in pil. No. x. Sig.—One at bedtime.

For a case of paralysis agitans in a man sixty-five years old, Prof.

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Bartholow prescribed hyoscyamine, gr. 1-80 once every day, and morning and evening, picrotoxin, gr. 1-60. As he presented the aspect of sclerotic changes he was also given the lactophosphate of lime.

A favorite laxative with Prof. Gross is:

℞ Rhei pulv..... gr. ij
Aloin..... gr. 1-5
Podophyli..... gr. 1-5
M. et ft. pil. No. 1. Sig.—At bedtime.

In a case of "drop wrist" in an anæmic woman, Prof. Bartholow gave, to eliminate the lead, a scruple of sodium iodide, ter die, well diluted and on an empty stomach. On account of the anæmia, the potassium iodide was contra-indicated, being a paralyzer.

Cholera Infantum and Summer Diarrhœa.—Cholera infantum is a dangerous disease, usually attacking children under two years of age, and is most prevalent in the summer time. Overcrowding, prolonged heat, bad drainage, contaminated milk and drinking water, and tainted foods are its chief promoters. It may arise *per se*, and quite suddenly, or may be the sequence of summer diarrhœa. Copious and frequent watery evacuations are followed by intense irritability of stomach, persistent rejection of food, thirst, feeble rapid pulse; temperature 105° or higher. Under these conditions, the child wastes in a few hours, and soon presents a wan, worn appearance, characteristic of the disease. Collapse, altered respiration and suppression of urine usher in the end. This form of disease is terribly fatal, far more so than the milder and more usual type, summer diarrhœa, which presents less pronounced but well-known symptoms, and is more amenable to treatment. Nevertheless, summer diarrhœa is very treacherous, sometimes killing in a few hours, through sudden collapse and fall of temperature.

Cholera infantum is best treated with sulphuric acid and other astringents, and opium, both internally and per rectum; two or three drops of laudanum in an ounce of mucilage of starch as an injection. A poultice of flaxseed and mustard, or turpentine stupes, should be applied to the abdomen; and carbonate of ammonia, or, preferably, whiskey—about ten drops—in a little lime-water, when collapse threatens.

The treatment of summer diarrhœa should be initiated by the administration of castor-oil or calomel, to remove the *materies morbi*, after which small doses of hydrargyrum cum creta, say one-third

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grain every two hours, combined with a little bismuth, soda, or rhubarb, according to indications, furnish a successful mode of treatment in many cases. Corrosive sublimate has also an excellect effect in doses of $\frac{1}{100}$ of a grain every hour,' in a little water. This latter remedy has been long employed; now we begin to recognize the scientific explanation of its action. A grain or two of oxide of zinc, every two or three hours, is useful, when it does not provoke emesis. A grain or so of acetate of lead, or of iron-alum, frequently repeated, succeeds sometimes. In many cases, one drop of ipecacuanha wine every hour in water has a remarkable effect. Sulphur in small doses has also been extolled, as also chlorate of potash, oxide of silver, camphor, capsicum and cold baths. A blister to the nape of the neck is useful. Thus, we have many so-called remedies, each having its advocates, yet none are reliable, and we are all the time losing large numbers of cases. We believe that many of these failures are due to delay when active treatment is called for, through the mother's thinking that the child is only suffering from the diarrhœa incidental to teething, whereas it is the victim of a far more serious condition and requires immediate attention. Perhaps the most important step towards securing a successful issue is the instant removal of the patient, when practicable, to a purer and wider air. All foods should be given sparingly and frequently; and the most useful dietetic agents during treatment include milk and lime-water, whey, raw arrowroot, raw meat-juice and white of egg dissolved in water. Some of the proprietary foods, as Nestle's, Horlick's, etc., are useful.—*Medical World, Aug.*, 1885.

Surgery.

Edited by G. FRANK LYDSTON, M.D., 125 State St.

Immediate Operation for the Repair of the Lacerated Cervix.—Dr. O. Roth, of Zurich, reports, in the *Deutche Medicinal Zeitung*, that he had occasion to perform the primary operation for the lacerated cervix immediately after delivery of the placenta, on account of profuse hemorrhage, and draws the following conclusions: 1. Deep cervical lacerations are apt to occur in older primipara. 2. Placenta previa predisposed to such an occurrence. 3. The tears ought to be sown up if they extend into the vaginal vault. 4. The suture is preferred to

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the use of the vaginal tampon, because the arrest of hemorrhage is more prompt and the danger of infection less great.

He then gives his method of operation which, for awkwardness and stupidity, could not be excelled. We would add that the operation is by no means so new as Dr. Roth appears to think, as we reported a series of cases more than three years ago, and have been operating in private practice more than four years, and we are fully prepared to answer his conclusions as follows:

1st. These lacerations are likely to occur not only upon older primipara, but upon any and all classes of patients, the fleshy or corpulent being the most liable.

2d. 'Tis the rapid delivery and rigid os, and not placenta previa that predisposes to lacerations. Placenta previa is a very rare incident, while lacerations of cervix, to an extent demanding operation, will occur in about one-third of primipara.

3d. Not only tears extending into the vaginal vault, but all tears in the cervix when discovered, should be closed immediately, not for hemorrhage alone, but (a) to lessen the chances of septic absorption, (b) to hasten the recovery of the lying-in woman (c), to avoid long-continued wasting of her strength by leucorrhœal discharges. (d) To save the expense and worry of the secondary operation, which must inevitably come. The doctor says the suture is to be preferred to the vaginal tampon, and we commend him for his wisdom (?) since the vaginal tampon is not only useless and nonsensical but positively harmful.

As to the doctor's manner of operating, it is never justifiable to introduce the hand into the vagina for the purpose of planting a stitch in the cervix, since it is so easy to bring the entire cervix in full view, when the vulva is so distended as we find it after labor. Catgut is a better suture than silk thread, and it never needs after attention. The parts need no dressing other than used in any other case of confinement. We have little patience with negligence in omitting to perform this operation, and little sympathy with those who labor so hard to make it appear to be difficult, since it is so easy, so simple, and so absolutely necessary.—EDITOR.

Cyst of the Vaginal Wall.—At a meeting of the Academy of Medicine in Cincinnati, Dr. Reamy reported an interesting case of cyst of the of the vaginal wall.

The patient, 27 years of age, married, has had two children, the youngest eight months of age. She entered his private hospital April

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13. Family history good, except that her father had a highly nervous temperament. She had the usual diseases of childhood, also variola when five years old, yellow fever at nine, and a protracted attack of typhoid fever at thirteen. Three years ago she had lobar pneumonia, and since then with pain in the upper portion of left lung. She was a picture of perfect health, a blonde of lymphatic temperament, and weighed 150 pounds.

Some months after the birth of her first child, attempting to get up, she noticed a sense of fatigue, a sense of weight in the pelvis, and a fullness in the vagina. Examining herself, she concluded she had prolapse of the uterus. A physician, being consulted, diagnosed rectocele. on detecting a fluctuating tumor on the posterior wall of the vagina. The woman was not greatly inconvenienced, enjoyed herself and weaned her child. She contemplated going East for medical aid, but before she started she discovered she was again pregnant. Nothing in her history showed that the tumor proved a barrier to delivery, although it seemed to increase in size somewhat during the progress of labor. Since then it has grown larger and the local and general distress greater.

Physical examination in the erect posture, revealed a tumor in the posterior wall of the vagina, which could be seen when the labia majora were slightly separated. The tumor almost disappeared when the patient assumed the dorsal decubitus, receding into the upper portion of the vagina. The tumor was about the size of a goose egg, and with the patient erect it appeared to be a very bad case of rectocele. Careful examination of the rectum convinced the doctor that it had no connection with that organ. It was a fluctuating tumor with no gaseous contents, hence, it was not enterocele. Cyst of the broad ligament was excluded, as was also anterior spina-bifida.

The day after the patient entered the hospital the tumor was aspirated, and about five ounces of fluid, perfectly limpid, exactly like that usually found in the cyst of the broad ligament. It was found now to be albuminous and to contain a few flat epithelial cells. Traces of chlorides were found.

Within ten days the cyst refilled to its former size, and being reemptied filled again. Still more certain that it was a cyst of the broad ligament it was determined to incise and empty the tumor. He not only made the incision, but button-holed the cyst wall so as to establish thorough drainage. Within twelve hours after the operation

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the patient was attacked with violent and protracted vomiting, which resisted every method of treatment for seven or eight days. Temperature, 99.5° F. and pulse went up at one time to 102. On the fourth day the stitches were removed and an iodoform compress inserted.

Examining the vagina on the 19th of May, it was found that the opening had not closed. Everting the walls of the cyst they were found to be in a state of inflammation and somewhat granular. The discharge was a little bloody. The interior of the sac was thoroughly explored with the finger, but no communication with the abdominal cavity or imperfection of the sacrum could be discovered.

The interior of the sac was now thoroughly curetted in all directions. An iodoform compress was inserted to compress the walls, with the hope of causing union. The former symptoms developed within a few hours continuing as before.

On the fourth day she complained of considerable pain in the nuchæ and the massetor region, but no opisthotonos. The vomiting was more uncontrollable than ever. Temperature 102°, pulse 120. Three days subsequently the temperature was sub-normal 97.5° F., and remained at that point for five or six hours. During this attack the pain was reflected sharply and distinctly into the left iliac and lumbar regions, as she vomited everything she was fed per rectum. In conclusion the doctor said he would next dissect out the sac or inject it, probably the latter after she had made a more complete recovery.

Necrosis of Lumbar Vertebræ of Obscure Origin; Rapidly Fatal Result. —On Sunday, March 22nd, I was sent for by Mr. Cooke, of Tettenhall, to see with him a young gentleman, aged fifteen, who had been complaining for some days of symptoms which were difficult to understand. On the Wednesday preceding he had called on Mr. Cooke, stating that he had a pain in the stomach, but not looking particularly ill, and doing his school work as usual. On the next day, not feeling so well, he kept his bed, and Mr. Cooke saw him. He then complained of severe pain in the back, which was tender to the touch, and in the abdomen, which was distended. His temperature was raised and his pulse quickened. He was very closely questioned as to whether he had had any accident or injury, but steadily maintained that he had not. Nor could it be made out that he had eaten anything injurious, the only questionable thing having been some preserved plum-pudding the previous Sunday. These symptoms—the abdominal

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distension and pain and the tenderness in the dorsal region—continued and increased, with a temperature which had risen to 102.5°, and a pulse of 100, until the Sunday afternoon when I saw him. At this time the patient was restless, flushed, moaning with pain, impatient of being touched anywhere, but shouted on any attempt being made to handle the greatly distended abdomen, or the back in the lower dorsal region, and for about three inches on each side of the spinal column. Temperature 102°; pulse 100; respiration 22. Six leeches had been applied to the back, and had given some temporary relief, but it was evident that the general progress of the case was rapidly down-hill. The bowels had been opened both by castor oil and enema, and there had only been a little sickness once. The urine was normal. Six leeches were again ordered, and opium was given to relieve the pain and the distension, which were thought to be due to peritonitis. Next day the condition was much the same; the symptoms perhaps somewhat relieved, but the general condition not improved. In view of what we considered to be the condition of peritonitis without any obvious cause, we thought that a surgical consultation was advisable, and the same day Mr. Vincent Jackson saw the case with us. He, however, declined to interfere by any surgical exploration, not considering such a step justifiable by the history or state of the case. The temperature had risen to 102.5°. The patient was somewhat delirious, loudly complaining if handled or moved in any way. For the next two days there was no material alteration in the symptoms. The temperature had once risen to 103°, but on the Thursday had come down to 100°, and tympanites and most of the tenderness over the abdomen had disappeared. The bowels opened naturally. Urine had to be drawn off by catheter night and morning. About this time appeared some swelling and tenderness in the left elbow, and the next day a red and painful swelling in the first two knuckles of the left hand, and in each place there was fluctuation. It was now evident that we had to do with a case resembling pyæmia, but what had given rise to it was not manifest. The boy was, however, put upon pretty frequent five-grain doses of quinine and some stimulants, with apparent temporary relief; but the temperature again rising very rapidly, the cold pack was employed, with the effect of keeping the temperature quite manageable. The stupor, however, increased, and early on the Sunday morning he died quietly.

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Autopsy, forty-four hours after death.—Cadaveric rigidty only in lower limbs. Red staining and leech marks on back. Abdomen distended and of a blue color. Head: Cerebral membranes healthy; veins fuller on right side than left; brain itself normal. Thorax: Left pleural cavity contained seven ounces of turbid serum; left pleura covered with a thick layer of recent plastic lymph making the lung adherent; right lung also adherent, but less markedly so; pericardium healthy; partly decolorised clots in both ventricles; heart itself healthy. In the upper lobe of the left lung were numerous small white lobules, some of which contained liquid pus. The lower lobe was collapsed, but floated in water. The right lung was crepitant in the upper lobe, but on the free edge were four wedge-shaped consolidated patches dark in color, and in these patches were small areas of softening. The rest of the lung substance was emphysematous in the upper lobe. In the middle lobe were similiar patches of consolidation with areas of softening. The lower lobe was almost solid, yellowish soft patches being scattered through its substance, some purulent and some apparently caseating. Spleen healthy. Liver: Pale, soft, and large; in one spot was a collection of pus about the size of a shot. Kidneys: Soft in texture, of the usual size, and rather dark in color. Intestines and peritoneum: Both healthy, with some post-mortem staining. In the first and second carpo-phalangeal joints of the left hand were collections of thick pus, extending from inside the joints and forming abscesses outside. On opening a slight swelling of the left elbow joint a collection of pus was also found infiltrating the joint. On turning over the body and cutting through the spinal muscles pus welled up in large quantities. The periosteum of the spinal canal was intensely inflamed, and the canal external to the cord was filled with pus, which was also infiltrated amongst the spinal muscles; but the visceral surface of the membranes of the cord was free from inflammation and healthy. On examination of the vertebræ, the body of the first lumbar was found to be quite soft and infiltrated with pus, presenting internally a marked contrast with the vertebræ above it and the one below, both of which were hard and of a dark livid color.

Remarks.—Here was a strong, robust, healthy lad, one of twins, with a good family history, suddenly and without ascertainable cause taken with a fatal illness which must apparently have begun in acute inflammation of the body of the first lumbar vertebræ, and presenting

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in a few hours all the symptoms of acute peritonitis, without, indeed, much constipation or sickness, but with great distension and extreme tenderness. The post mortem examination revealed a large quantity of pus, infiltrated amongst the deep muscles of the loins; but during life the most careful examinations only produced extreme pain without any feeling of fluctuation. The changes in the lungs were also quite a revelation, as during life the breathing, beyond being a little hurried, was only slightly affected, and only a few mucous rales were audible on auscultation except on the last day, when some dullness was discernible. The post-mortem examination, which was performed by Dr. Dingley of the Wolverhampton Hospital, was a most tedious business, and the nature of the case was only got at by carefully tracing the various lesions up to their fountain head. And even now the origin of the disease is a mystery. What caused the acute necrosis of the lumbar vertebræ? There is no history of a blow or a sprain, or even of a strumous tendency. I must content myself with putting it on record as a curious case, having no theory to advance which will satisfactorily explain its origin.—*James Y. Totherich, M.D., in Lancet.*

Diagnosis of Early Cerebral Syphilis.—Dr. F. B. Geenough, in a paper on cases of cerebral symptoms in early (secondary) syphilis, (*Boston Med. and Surg. Jour.*), states that the diagnosis of these early cases of cerebral syphilis is very much simplified by the fact that they occur either while the symptons of constitutional infection on the cutis and mucous membranes are still apparent, or so shortly afterward that the fact of the patient's having recently had syphilis could not very well be ignored. Their diagnosis, however, by no means depends on this point of time alone. The fact that the attack had been preceded by the characteristic headaches would be of importance. The muscular paralysis in these cases is always, at first at least, an incomplete one; loss of power or of control of one arm or leg, or both, is first noticed, and this gradually increases. A certain amount of aphasia, or rather a hesitancy in speech, seems to be a pretty constant symptom. The comparative youth of the patient in many cases is of diagnostic value. Lastly, the fact of the symptoms improving under specific treatment would, of course, decide the question. The lesion which is most likely to be confounded with these early cases of cerebral syphilis is an embolus of a central artery. In such a case, however, the symptoms of paralysis would come on more suddenly,

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be more complete, and there probably would be some indication of the cause of the embolus.—*St. Louis Med. Jour.*

A Case of Conservative Surgery.—March 31st, 1884, I was called to see J. C. I found, in hygienic surroundings, as bad as can well be imagined, a pale, emaciated boy, fifteen years of age, lying in a filthy bed, which was saturated with blood.

A few hours previous to my arrival the boy sat in a chair, about twelve feet from an elder brother, who was repairing a musket which was heavily loaded with No. 4 shot. The gun was accidentally discharged. The whole charge passed through the boy's left knee-joint.

For several years the boy's health had been poor. During a few weeks before the accident he had been confined to his bed, suffering with fever, cold sweats and and a troublesome cough.

I found a large, ugly-looking wound. The leg seemed to have been flexed to a right angle with the thigh, the charge entering immediately above the head of the fibula and passing directly through the joint under the patella.

The articular ends of the femur and tibia were torn away. The whole compact tissue of the inner condyle of the femur protruded through the wound intact.

The boy's pulse was imperceptible. He appeared to be in a dying condition. Hemorrhage continued, which I checked by packing the wound with sublimated absorbent cotton. I put the limb in a temporary splint and directed liberal doses of quinine, whiskey and milk to be given.

The next day I found the pulse at 140 and stronger; temperature, 102°. I carefully cleansed the wound, removed eight or ten pieces of loose bone, put the limb in an interrupted plaster bandage, and gave tonics and stimulants.

Several days after the accident a consulting physician thought an amputation would be useless, as death seemed inevitable.

For three weeks I thoroughly washed the wound once a day with sublimate water, frequently removing pieces of loose bone. I then left the case to the care of the parents. I never found the temperature above 102°, but I did not find it below 100° during the first two weeks.

About ten weeks after the accident I removed the plaster. The wound had healed with the exception of two or three small sinuses leading down to the dead bone. The long bones were firmly united. There

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was little deformity except a shortening of about four inches. The boy soon began to walk with a crutch. The cough, which he had had for more than a year, ceased, and his appetite and digestion became better than for two years before.

I have not seen the patient in a long time. His parents say he is able to walk without a cane or limp, and to do work in the field. His general health is good. At long intervals a sinus has opened and a piece of bone come away.

I believe recovery from such a serious wound at the knee, without an operation, is generally thought improbable.

In regard to the improvement of symptoms which existed before the accident, the history of which would lead one to strongly suspect phthisis, I will advance no theory.—*C. S. Parke, M.D., Hubbardston, Mich., in Med. Age.*

When to Begin the Treatment of Syphilis.—The conscientious physician who is called upon to treat a case of syphilis is always anxious to give his patient the benefit of any doubt that may exist, and not only this, but he is also solicitous to see that his patient gets the full benefit of the treatment instituted. As an introductory to the subject to be considered, it may be premised that the certainty of diagnosis of the initial lesion is, as a rule, inversely proportional to a complete knowledge of the subject. The merest beginner in medicine will unhesitatingly pronounce a diagnosis where the experienced specialist will hesitate. The one appreciates but a few out of a number of possible complex symptoms, all of which are quickly recognized by the other. The consequence of this is that the new beginner frequently makes mistakes, and so often covers them by greater ones that it becomes a very difficult matter to arrive at a just conclusion later on.

The proper time to begin the treatment of syphilis, or what is generally called the constitutional treatment, is when the so-called secondary symptoms make their appearance. This is not only more rational, but it is safer, more thorough, and it is the only method by which the patient is given the full benefit of any doubt that may exist.

All are doubtless aware of the fact that the chancre, or initial sclerosis, is that sign which first appears to show that syphilis has invaded the economy. We will not discuss here the question as to whether it is a local manifestation purely, or a symptom of general infection. The numerous experiments made to entirely destroy this lesion by cauterization, excision, etc., have failed to avert further manifesta-

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tions, and we feel justified in regarding it as a local symptom of a general infection. Now, if this lesion possesses all of the characteristics of the typical chancre of syphilis, there is but little difficulty in recognizing it. If, on the contrary, it exists in an unusual locality, or has developed in an abnormal form, it will not be so readily recognized. Again, a purely local venereal sore may present many qualities similar to those of the infecting chancre, and in such a case we will have some difficulty in appreciating the situation. It is not every one who can recognize or rather differentiate induration from circumscribed inflammatory infiltration, and a supposed indurated chancre may turn out to be but an infiltrated chancroid or vice versa. The mere fact that a venereal sore is suppurating is no proof that it is non-syphilitic as the chancre when irritated will become inflamed and pus will follow, as a natural consequence. When the chancre occurs on a mucous surface it frequently never has an indurated base, or it is one in which the characteristic hardening is so slight that it escapes attention. The time of incubation, so often relied upon in making a diagnosis, very frequently cannot be depended upon, especially if the subject has been indulging in promiscuous intercourse, a condition which also greatly militates against diagnosis by confrontation. When we consider all these points, in connection with the diagnosis of the initial lesion, it becomes apparent that the question of giving the patient the benefit of the doubt is an important one.

Whether the diagnosis be positive or doubtful the treatment remains the same. If the chancre be non-infecting, and has been diagnosed as infecting, simple detergent measures and internal tonic treatment will not have any tendency to retard cure. On the contrary, you are placing your patient under the best possible conditions to ensure rapid granulation and cicatrization of the ulcer. Should it, however, be an infecting chancre, whether recognized as such *ab initio* or not, the same treatment will be proper. The chancre will heal spontaneously in any case, and detergent measures are our mainstay now in surgical procedures and always in order. The simple tonic treatment has the effect of counteracting the anæmia and debility which always accompany syphilis, and besides places the patient in the best possible condition for the siege he is about to undergo. Then, when the secondary lesions appear, the specific tonic treatment, the mercurial, is in order and should be pushed vigorously.

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The question will be asked, "Why not give mercurials immediately and avert the appearance of the secondary symptoms? Or why not give it in doubtful cases?" To the first we will answer that there are several reasons. In the first place mercurials, given immediately after the appearance of the chancre, do not prevent the appearance of secondary symptoms, they merely delay them, even should the patient faithfully take his medicine. In the second place the patient will take the remedies ordered, but for a short time, as he will regard himself cured, never having observed anything beyond the primary sclerosis. He will later on, after a greater or less interval of time, have relapses which will be often difficult to control. In doubtful cases you place a patient under treatment who perhaps never had syphilis. He is not certain of it nor is his physician, and he may be informed later on by some one else that if he had syphilis it may reappear at any time; if he has not had it, it will not. Try to imagine the mental state this would bring about in a sensitive person. It is giving the benefit of the doubt with a vengeance. If, as advocated in this paper, you wait until the appearance of secondary symptoms and the patient observes them, he will be impressed with the importance of the disease with which he is afflicted. He will more readily observe the directions of his physician, and he will have more faith in him, as he sees those lesions disappear under appropriate treatment. Again, if no secondary symptoms appear within a certain limited time, the patient can be assured that his disease was purely local, that he is still untainted, and he may be sent on his way rejoicing that he has escaped a disease regarded with such horror by the majority of humanity.

Is there not time lost in delaying specific treatment until the appearance of the secondary symptoms? By no means. The patient, properly instructed, will discover the first erythematous blush or roseola and will be quick to see that it is properly cared for; this will rapidly disappear under appropriate treatment and he will in the interim have gained strength and greater power to resist not only the effects of the disease, but any untoward effects the medicines might exert. Besides this, a certainty of the existence of the disease is established.

These are but a few of the numerous reasons adduced for this method of treatment; it would require more time and space than your patience would permit to go fully into the subject. Cases have not

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been brought forward in support of the views advocated as very few men are in a position to show a sufficient number to carry conviction. Fournier, of Paris, one of the best living authorities on syphilology, has treated thousands of cases of syphilis in the institution which furnishes the largest number of any in the world, my hearers will readily recognize that I refer to l'Hopital St. Louis. The result of his observations through a series of many years is such as I have given and it was not arrived at hastily, but is the fruit of years of labor and thought. In fact, the majority of advanced syphilographers are now agreed that such is the proper course to pursue. In comparison my own few cases, of course, pale into significance; yet, it is always gratifying to us to be able to confirm personally the experiments of others and I can heartily testify to the success which attends this method of treatment. And I have yet to see the first patient who has ever objected to the few weeks he was compelled to wait in order that he might have proof positive of the presence or absence of syphilis.

Nothing has been said of specific treatment as it is a subject too vast to embrace within the limits of a short paper. Nor has any reference been made to various special forms of the initial lesions where special treatment, local and general, is sometimes indicated. The aim has been rather to call attention to a subject which seems, as yet, to be but little appreciated by the general practitioner who very often has but rare opportunities of observing cases of syphilis from their inception.—*Dr. A. H. O. Dumesnil, in St. Louis Med. Jour.*

Transplantation of Bone.—We learn from a lay contemporary that Professor Bergmann, of the Zeigelstrasse Hospital, Berlin, has recently had a successful case of transplantation of bone in the human subject. The operation is not new to science, for Ouiver of Lyons, and others, have shown that in the lower animals portions of bone may be readily grafted on to a freshened surface. As in all other measures taken with a view to the restoration of lost tissues or members, the difficulty increases as the scale of development is ascended; or, in other words, the more highly organized and specialized the elements of a part, the less is the tenacity of their life. There is a certain amount of energy distributed in the body for growth, development, and repair, with discharge of functional activity. At first sight it seems surprising that transplantation of bone has not been more extensively practiced on the human subject. The explanation

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is simple and ready to hand. In cases of fracture, even with loss of substance from detachment of splinters, nature is full of resources for replacing the necessary material; and again, it is well known that the entire shaft of a long bone may be excised within a few days of its destruction by suppurative osteitis, and a new one be regenerated with tolerable certainty. It is not for such cases, then, that transplantation of bone is likely to be required; but in those more numerous instances where the osseous tissue is eaten away by insidious disease. Unfortunately for the patient, the vitality of the surrounding bone is usually too low to warrant any great hope of the method of extrinsic repair now under consideration. In order that the graft may "take," a rapid vascularisation of the callus is necessary, but in caries the organising power, except in rare cases, is too feeble. Still, there is no telling what surgical science and art may eventually accomplish, and for that reason we look forward with curiosity and interest to the future records of bone-grafting.—*London Lancet.*

Eye and Ear.

Edited by J. E. HARPER, M.D., 163 State St.

Operation for Malformed Auricle.*—On July 11th, Nettie H., eight years old, presented herself at my clinic, at the Illinois Charitable Eye and Ear Infirmary and said that she "wanted her ears put back." Both auricles were so abnormally prominent as to mar materially the symmetry of a very shapely face and head. The left auricle, which was the more unsightly of the two, projected 1¼ inches at a right angle from the junction of the auricle with the mastoid process, and then bent forward; thus forming what is facetiously termed "lop ear" or "dog ear." The natural elevations and depressions were obliterated, and the organ presented the appearance of having been flattened by the pressure of the head in sleep on an ear folded forward upon itself. The right auricle projected one inch; but was not so imperfectly shaped as the left one.

At first I contemplated moulding the auricle into shape in a dressing of plaster-of-Paris, which would retain the parts in position for several months, with proper care and renewed dressings. But on account of the youthfulness of the child, which would render it highly

*Read before the Chicago Ophthalmological and Otological Society, Aug. 16th, 1885.

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improbable that she would co-operate in that treatment with sufficient persistence to insure success, I performed an operation, with the consent of her parents and the assistance of Drs. Hawley, Abbott and Walker.

On July 17th, the little patient was anæsthetized with ether. An incision 1¼ inches long was made on the posterior surface of the auricle, about ⅓ inch from the free border of the cartilage and parallel therewith. Another curvilinear incision internal to the first was made to unite its extremities. These incisions extended only through the skin and subcutaneous tissue and were made to embrace about one-half inch of skin, at the widest divergence of the lines of incision. After dissecting off this skin and subcutaneous tissue, two incisions parallel to the first were made through the cartilage, and an elliptical section of this was dissected off from the skin covering the anterior aspect of the auricle without wounding that integument. The portion of cartilage removed was not quite as wide or long as the section of skin taken from the posterior surface of the auricle. The edges of the wound were united by three sutures, which included the skin only, and the parts were dressed with absorbent cotton and net bandage. Union by first intention occurred and the sutures were removed on the fifth day. However, the patient chose a pleasure excursion in preference to the clinic before the wound had healed thoroughly; the dressing was displaced and the wound was torn open along the center. Consequently this portion of the wound healed later by granulation. There was but slight pain or swelling, and the child evinced no dread of an operation on the other ear, except with respect to the ether.

The result of the operation is that the auricle now projects but three-fourths of an inch instead of 1¼ inches, making a difference of ⅓ inch between the projection before and after the operation; and the natural elevations and depressions which are requisite to the beauty of a well-formed ear have been restored.

I do not know that any surgeon has previously performed an operation identical with the one I have devised; but when a learned professor informs the French Academy of Sciences that before the illustrious Jenner was born, and "from a period so remote that it loses itself in the night of time," the inhabitant sof Senegambia have practiced inoculation for the prevention of a contagious disease, I have not the temerity to call any operation new. Recently I congratulated

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myself on having originated another new method of treatment, when, to my surprise, I learned that Dr. Seaton, of New York, had been experimenting in the same direction, although he had not published the fact.

Drs. Ely and Roosa have operated in a different manner to effect a similar result. They transfixed the auricle at its junction with the side of the head, and removed the cartilage and the skin covering both, the anterior and posterior surfaces. By my operation it is apparent that the integument covering the anterior surface of the auricle, or the part most exposed to view, was not at all injured. I was not able to ascertain the exact results in Dr. Ely's case. In Dr. Roosa's case the projection before the operation was the same as in mine, but the projection in my case after the operation was $\frac{1}{8}$ of an inch less than in his.—*S. S. Bishop, 139 Centre Ave.*

Foreign Bodies Removed from the Eye by Electro-Magnet.—Dr. Simeon Snell in the *Brit. Med. Jour.* for May 2nd, 1885, reports eighteen successful cases of metallic foreign bodies removed from various parts of the eye by the electro-magnet. To be most favorable for the preservation of vision, the interval between the receipt of the injury and its extraction must be short.

Tinnitus Aurium and Nervous Disease.—It not infrequently happens to the physician that he is called upon to treat a case of obscure nervous trouble, one in which after a careful review of all the symptoms which may be more or less distinct, he is at a loss to determine what the nature of the trouble is and where it is. Diligent search is made for some offending organ, but all seem to be performing their functions in a healthy manner. one organ, however, has escaped attention, as it usually does in these cases, and that is the ear. Why this should be so, why the profession should entirely leave out of consideration affections of the ear, so often the source and possible cause of general constitutional disturbance, and more especially their effect upon the nervous system, we cannot understand. When its close proximity to the brain is considered, when it is remembered that it is intimately connected with other organs and systems of the body by nervous and vascular supply, a neglect to give to it the attention which its importance demands would seem to be culpable. These thoughts have been suggested by a perusal of a report on tinnitus aurium read at the annual meeting of the Association of Superintendents of American Institutions for the Insane by Dr. Geo. C. Catlett, superintendent of the lunatic asylum at St. Joseph, Mo.

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In this very interesting paper the writer relates a case which serves to illustrate the ideas expressed above. The patient had had scarlet fever for four years previous to his admission to the asylum with subsequent discharge from both ears lasting through the four years. He became eccentric, restless, self-willed and suspicious of those around him fearing personal injury. He had insomnia, and in walking always described a circle, going around to the right. The tinnitus assumed the character of voices talking to him. He was so obstinate that it was necessary to put him under restraint in order to examine and treat his ears. The auditory canals were found obstructed with hardened dry pus and cerumen. Upon the removal of this, and subsequent treatment of the ears the patient returned home in four months sane and apparently well of his aural trouble. Now, can there be any doubt that if this patient had received the proper treatment at the beginning of his aural trouble his after-attack of insanity would have been prevented? We think not. In this case, however, there were symptoms pointing so directly to the ear that it was not possible to overlook it. But in those cases where there is doubt and inability to locate the cause of the nervous symptoms, we believe that a careful examination of the ear would often reveal the existence of trouble sufficient to account for the patient's condition, the treatment of which would afford the desired relief. We are confident that our views on this subject are borne out by the record, and we should be glad to see affections of the ear receiving more consideration at the hands of the general profession.—*St. Louis Courier of Medicine.*

Pilocarpine in Sudden Loss of Hearing.—Dr Thomas Barr reports in the *British Medical Journal* material improvement in two cases of sudden loss of hearing from the hypodermic use of pilocarpine. The trouble was in the nervous structure of the ear. He has used it in labyrinthine trouble coming on gradually, but with no effect. Politzer, who was the first to propose this remedy, used it chiefly in cases of nervous disease of recent and sudden occurrence, and especially in those of syphilitic origin. As to the explanation of the therapeutic action of pilocarpine, we can only assume that it has an especial power of stimulating the absorbents in contact with the effused products before these have become organized. It seems to have a more decided action upon the intracranial absorbents; and the vascular and lymphatic supply of the labyrinth is in reality the same as that of the in-

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terior of the cranium. If this view of its action be correct, it would be reasonable to employ this method of treatment more generally in cases of cerebral apoplexy.

Diagnosis of Earache in Children.—An intense, almost continual cry, bespeaking great pain, denotes otalgia; or middle or external otitis, if the child moves its head restlessly on the cushion and puts its hands often to its head.—*Politzer, Jahrbucher fur Kinderheilkunde.*

Prophylaxis of Blennorrhœa Neonatorum (*Deutsche Med. Zeitung*). Dr. Horn reports that 33 per cent. of the blind in the institutions of Germany and Austria accquired their blindness by blennorrhœa neonatorum, and Daumas states that he found among 1078 blind 817, or 69 per cent., who became blind through the above mentioned disease. These reports prove how often incurable blindness results from purulent conjuctivitis of new-born children, and how many cases there are with slight or great visual defects on one or both eyes which are not included in these figures.

The foregoing facts seem to justify the employment of Crede's method of prevention against such occurrences. A great many investigations have resulted in the conclusion that the disease is caused by the specific virus of gonorrhœa, and that the simple catarrhal secretions of the genitals never causes specific infection of the eye, but in very rare cases only simple catarrh.

Crede's method is this: Just after birth the child is given a bath, the eyes are not cleansed with the same water, but with absorbent cotton or pieces of linen soaked in clean water. Before the child is dressed, one drop of a two per cent. solution of nitrate of silver is dropped in each eye, but only *one drop*, and that should not be repeated.

There exists no difference of opinion about the value of Crede's method. Crede himself, after introducing his preventive treatment, has had in

1880 one case out of 211 new-born infants.
1881 " " " " 400 " " "
1882 two " " " 418 " " "
1883 none " " 131 " " " (in a period of three months.)

Bayer reports from the Stuttgart state institution for midwives, that in the year 1879, out of 396 new-born infants, 51 were affected. In 1880, out of 354, 34 were affected, and in 1881, after Crede's method was adopted, not a case occurred. A later report from the same

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institution showed one case among 978 infants. There are several reports which prove the eminent reliability of Crede's method, but the question arises whether its use might not in some cases be disadvantageous. Crede himself denies it. Only in a few cases after application he noticed a greater hyperæmia of the conjunctiva. Others have noticed the same effect. I. G.

Editorial.

The Tempest in the Teapot.—Our readers may have noticed in former issues of the REPORTER a conspicuous absence of comments upon the war cloud, which now obscures the bright horizon that erst-while encircled the coming International Medical Congress. We assure our readers that our silence has not been due to indifference upon our part, for the matter is certainly one of vital importance to every medical man of a progressive mind. There seemed however, to be no probability that the prominent gentlemen who are most closely indentified with the best interests of the American medical profession, would so far forget themselves, and that spirit of liberality and scientific progress which has been pre-eminently the claim of the profession of the United States, as to seriously embroil themselves in a quarrel that could but engender the contempt of the majority of the profession, both at home and abroad; we now however, appreciate our mistake. To open the closet and exhibit to the world the skeleton of the American medical family, "the Code," was indeed, in very poor taste, to say the least, especially when such an exhibition was absolutely certain to prove prejudicial to the coming congress. It seems a trifle peculiar that we Americans, with all our boasted liberality and freedom of thought, should be the first to cast a stone at the medical free thinker, and it may well seem a trifle parodoxical to the scientific representatives of what we are prone to term the effete governments of the old world, to find the future of the international congress endangered by the intolerance of American physicians.

Our European brethren may perhaps appreciate the fact, that the American Medical Association, in its action regarding the congress has not voiced the sentiments of either the majority, or the best of the members of the profession in America, but we are none the less disgraced in their opinion. It is perhaps wrong to lay this trouble at the door of the association as a whole, for as in every other organiza-

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tion of a similar character, it will be found that the active management is in the hands of a very few individuals, but as the matter now stands, there is nothing else to bear the responsibility of the family quarrel. With all respect to its venerable editor, the *Journal of the American Medical Association* appears to be the only obstacle in the way of an amicable re-arrangement of the committees, and a resumption of the strictly scientific work, which if undisturbed, will make the coming congress fully as successful as any of those which have preceded it. Pertinacity is an excellent quality under exceptional circumstances, but in the present instance, concessions for harmony's sake, would be in much better taste. The time is past for a body of men, scientific or otherwise, to attempt to forcibly coerce the opinions of the majority, and experience has taught the profession within a very few years, that the code question had better be left to take care of itself.

The physician's own conscience is his most trustworthy mentor. He may from that purest of motives, honesty, decline to consult with one whose views are so dogmatic, and so diametrically opposed to the results of scientific research, that there could not possibly be any interchange of ideas which would be liable to redound to the patient's advantage. To accept a fee for such a consultation would be akin to larceny. To consult with a man who meets a consultant, not as a "-path," or an "-ic," but as a respectable physician, is however above reproach, whether both are recognized by the Association or not. The propriety of a consultation ought to be determined by the characteristics of the men, and not by the school which has empowered them to practice. The relation of a certain proportion of physicians to the mass of the profession is a trifle like the old story of the pigs in the clover patch. They have protected themselves by a barbed-wire fence denominated "the code," that plainly says to the fellows upon the outside, "Thou shalt not steal." The favored ones have always seemed to be strangely familiar with the spaces between the wires, and, in case their less fortunate brethren should find a few plums upon their side of the fence, they have always been perfectly willing and eager to rush out and help themselves; now, however, that the outsiders have shown themselves both able and willing to jump clear over the wires, the protest of the fat fellows is most vehement. It is a singular fact, that the young man, who graduates at a reputable college, and settles down in a new locality to earn his bread and

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butter, will meet with less courtesy and more bitter opposition, at the hands of the gray-haired adherents of ye venerable code than at the hands of the "irregulars." We have known instances in which the aspirant to medical fame has had his first cold water bath at the hands of men whose names he had been previously proud to read upon his diploma.

How long the profession will continue to depreciate itself in the eyes of the public by unseemly strife, is a question, but the millenium is devoutly to be prayed for. The explanation of the fact that the medical profession commands so little respect at the hands both of the laity and various municipalities, is simply that its members are continually employed in cutting each other's throats. They are expected to labor for nothing,—or what is worse, glory,—and to devote themselves to the welfare of a thankless public, simply because there is not among them sufficient professional esprit du corps to encourage them to battle for their rights. Should a surgeon refuse to work for the state, city, or any private croporation, for nothing, or, at most, for a mere pittance, there are a thousand others who will jump at the chance if offered them. Doctors do sometimes refuse to accept glory from conscientious motives, as is illustrated by the resignation of so many gentlemen whose names graced the committees for the coming Congress. As our respected contempoary, the *Medical Age*, has aptly remrked, "even the Michigan men have resigned their exalted positions upon the committees, and when a Michigan man resigns an office, there must be something rotten in Denmark." If the statement had been a trifle more comprehensive, and had embraced the profession as a whole, it would have been quite appropriate. There is no one, however, who is better qualified to express an opinion regarding the Wolverines than the editor of the *Age*. We will live in the hope that the cement of brotherly love will be spread on hot and thick at the St. Louis meeting next year, and that certain prominent members of the Association may become quite expert in the use of the trowel by that time. We fear, however, that there will be no peaceful interim in which to practice the new and to them novel exercise. There are others, too, who might find profitable employment in professional tailoring, in order that our poor skeleton, the code, may be provided with garments new wherewith to cover his unseemly nakedness; in case the profession is bound to trot him out for the

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edification of the scientific world at the next meeting of the Association. G. F. L.

Queries and Answers.—We wish to call the attention of our readers to a new department in the REPORTER which we hope to make a very valuable feature. The department will bear the above heading, and as its name implies will be devoted to inquiries and answers concerning practical question in medicine and surgery. Both queries and answers will be made as concise as possible, and principally confined to diagnosis and therapeutics. In order to get the department started and test its value, we hope that every reader of this issue will send us some question in which he is interested for answer in our next. All questions received will be referred to the editors of the department to which they belong.

Miscellaneous.

Vaginismus Extraordinary.—Dr. F. Y. Davis, ex-United States Army, narrates the following case in the *Med. News:* While practicing in Pentonville, England, he was called at about midnight to see a case quite unique. The gentleman calling him said that about bedtime, as he went into the back kitchen to see if the house was shut up, he was attracted by a noise in the coachman's room. On going there he found the coachman in bed with one of the maids. She screamed, he struggled, and they rolled out of bed together and made frantic efforts to get apart, but without success. He was a big burly fellow, over six feet high, and she was a small woman of not more than ninety pounds. She was moaning and screaming, and seemed in great agony, so that after several fruitless attempts to get them apart, the doctor was sent for. When he arrived, the man was standing up supporting the woman in his arms, the penis being locked in her vagina. After trying to liberate the organ with water and ice, and failing, chloroform was administered. A few whiffs of this put the woman to sleep, and released the penis. This was swollen, livid and very sore, and was in a state of semi-erection, which did not go down for several hours, and for days the organ was very painful. It must have been that there was a spasm of the sphincter at the orifice of the vagina, which nipped the penis and prevented the outflow of blood from the organ— *Weekly Med. Rec.*

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Personal.

PROF. R. L. REA.—It is with regret that we announce the retirement of this distinguished teacher from active duty as a lecturer. For more than a quarter of a century he has been one of the most industrious and successful teachers of medicine in this country, as thousands of his pupils throughout the land can testify.

He was demonstrator of anatomy for two years in his alma mater, the Ohio Medical College. He was professor of anatomy for sixteen years in Rush Medical College, and taught the same branch for four years in the Chicago Medical College. He has been for the past three years professor of the principles and practice of surgery and clinical surgery in the College of Physicians and Surgeons of Chicago.

When he withdrew from the Chicago Medical College his intention was to give up teaching, but the temptation of closing his quarter of a century of lecturing in an institution of such promise as the College of Physicians and Surgeons was sufficient to place him again in harness where he labored with renewed energy. Having accomplished the aim of his ambition as a lecturer, he has decided to retire permanently, notwithstanding the earnest protestation of his collegues in the faculty and the universal regret of his pupils. His reply when urged to reconsider his resignation, is characteristic of the firmness and earnestness of purpose which has marked his career thus far in life:

"In associating myself with the College of Physicians and Surgeons, I did so with the intention of retiring as soon as I had assisted it to a secure position. The annual increase in the number of students, the success these have achieved in competitive examinations for hospital appointments, and their enthusiasm in the work convince me that my object has been accomplished, and that with my vacancy properly filled, with harmony, good management and faithful work, the College of Physicians and Surgeons will continue in the very front rank of American medical colleges."

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Medicine.

Edited by WM. E. QUINE, M.D., 3151 Wabash Ave.

Nervous Symptoms of Enteric Fever.—The following are the conclusions reached in an article by Dr. J. C. Wilson, published in *Medical Times:*

1. The so-called typhoid condition (stupor, somnolence, hebetude, prostration) is dependent upon the alteration of the blood caused by the infecting principle. It may be said that the intensity of these symptoms is proportionate to the virulence of the infection.

2. Delirium (especially when violent) and agitation, in a word the ataxic phenomena, are produced by the same pathogenic principle. But their manner of development and their course are to a great degree influenced by the pyrexia. The fact, however, must not be overlooked that certain forms of delirium occurring in enteric fever are not dependent upon the elevation of the temperature.

3. Certain forms of delirium, especially delirium ceasing after free epistaxus, and certain muscular disorders, such as convulsions and contractures, must be ascribed to hyperæmia. Disturbances of sensation are likewise in many instances the result of congestion of the nervous centers.

4. Vertigo, delirium, etc., may also be due to anæmia, which plays an important part in the production of enfeeblement of the central nervous system. Collapse is very often due to abundant hemorrhages. Inanition, producing, as it does, a profound denutrition, is a

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cause of anæmia, and favors the collapse and marasmus, which are so often fatal.

In conclusion, whilst intense pyrexia is the cause of serious symptoms and grave complications, it is possible to assign to it a high position as a pathogenic factor. The dictum of Griesinger, "The fever in great part controls the situation,"—*Das Fieber beherrscht zu grossem Theil de Situatiòn*—has exposed those who have accepted it to grave therapeutic errors. The nervous phenomena of enteric fever are produced by various causes which act sometimes together, sometimes separately. It is not easy to discover the predominant element in a pathogeny always complex, nor is it desirable to carry the analysis to an extreme. From a clinical standpoint, however, the subject is important, for the management of the nervous symptoms will be successful in proportion as their interpretatation is exact.

Endocarditis.—In the *Brit. Med. Jour.* of March 7, 14 and 21 are found the Gulstonian Lectures delivered by Prof. William Osler, of the University of Pennsylvania. These lectures give the most complete exposition of the subject of ulcerative endocarditis, or, as he prefers to call it, malignant endocarditis, which has yet been made.

There may be an acute or a chronic form. Anatomically, the acute form may be subdivided into various forms, as the plastic, papillary, verrucose, fungous, ulcerative, etc.; etiologically, the varieties are as numerous as the diseases in which it occurs, as puerperal, scarlatinal and the like; clinically, we have two classes, the simple and the grave. Cases are said to be primary or secondary, but there can be found to exist no essential anatomical or pathological differences. Anatomical classification would group together cases widely different, clinically. The term ulcerative is in general use, but does not include those cases where no actual destruction of tissue has taken place, and yet manifest severe constitutional disturbance. The clinical classification into simple and malignant cases, whether ulcerative or vegetative, is the one of most practical value.

Malignant endocarditis occurs as: 1. A primary disease of the lining membrane, rather predisposed to by constitutional debility or previous valvular disease; 2. A secondary affection to many diseases, especially rheumatic fever, pneumonia, scarlet fever, diphtheria, ague; 3. An associated condition in septic processes, traumatic or puerperal. The lecturer then discusses in order the anatomical,

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the clinical, and, lastly, the etiological and pathological characters of the disease.

The lesions, by no means uniform, may be vegetative, ulcerative or suppurative, either alone or in combination, and in all degrees of intensity. He relates a case which proved fatal, the endocardium showing simply vegetations without ulceration. The combination of ulcerating and fungating outgrowths he thinks the most common condition. The ulceration may vary from simple abrasion to destruction of a valve or deep involvement of the muscular substance. The vegetations vary considerable in appearance and consistence, from soft, greyish-white masses to large cauliflower excresences, with deep jagged fissures, or long pendulous, stalactitic masses. The friction of these masses against the wall may produce numerous smaller vegetations. Conservative changes may take place; fibroid induration of the deeper parts, the superficial remaining unchanged or necrotic. Two conditions are to be distinguished from maligant endocarditis, viz: atheromatous degeneration in sclerotic valves, and the firm, white globular thrombi of the auricular appendices and of the interstices of the columnæ corneæ of the ventricles.

Histologically, fresh endocardial vegetations are made up of round and fusiform cells derived from the sub-endothelial layer. Varying with the rapidity of the growth the mass will resemble granulation-tissue of a fibrous outgrowth. Sometimes a cap of fibrin is deposited on the growth, and in this are found, more or less abundantly, the blood-plates of Bizzozero.

The larger vegetations consist of a granular material, composed of altered and dead tissue elements, fibrinous exudation and colonies of micrococci. He regards the micrococci as constant elements in these vegetations. They vary greatly in number and arrangements, occurring singly or in groups, most abundant in the deeper layers. Some of the smaller vegetations seem almost exclusively made up of them. Klebs has distinguished two forms, one found in septic, the other in rheumatic cases. Small elongated bacilli have also been found, and Cornil, having found the bacillus tuberculosis in endocardial vegetations in a case of phthisis, expresses the opinion that we shall, before long, have accurate knowledge of a variety of micro-organisms in endocarditis, depending upon the nature of the primary disease.

The local effects of the ulcerative changes are important. Peforation of a valve-segment is extremely common, the hole being clean-

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cut or irregular, or sometimes great fungous vegetations may completely close and conceal the perforation. Erosion of the chordæ, ulceration of the heart-muscle, leading to perforation of the septum or of the wall of a chamber, the production of aneurisms of the heart or vessels, are some of the effects.

Sclerotic or malformed valves are especially prone to acute inflammation and fusion of two aortic cusps is nearly always followed by sclerotic changes.

Of associated pathological changes, we have, first, those connected with the primary disease, and second, those resulting from embolism. These latter may be divided into "those without embolic processes, cases in which the infarcts are simple, not suppurative, those in which there are innumerable suppurative infarcts," and mixed cases. In marked malignant cases these embolic features may be absent. They may not be suppurative, but simply hæmorrhagic, though in traumatic and puerperal cases the infarcts are invariably septic. The spleen is most often the seat of infection, then the kidneys. The lungs are usually affected when the right side of the heart is involved. These infarcts may be found also all along the gastro-intestinal tracts, forming in some instances numerous miliary abscesses. Gastric ulcer has resulted in this manner. The liver may be similarly affected, and pleurisy and pericarditis are not uncommon complications. The cerebral lesions may be meningeal or of the brain substance, manifested by meningitis or various paralyses.

It would be difficult to present a satisfactory clinical picture of this disease. The general symptoms are those of a febrile affection of variable intensity, ushered in with rigors, pain in the back, vomiting, headache, etc. Prostration, delirium, sweating and other signs of severe constitutional disturbance are generally present. Arising in the course of some other disease, the symptomatology partakes of that of the primary affection, additional symptoms and signs manifesting themselves, owing to the local cardiac implication and its results.

So diverse are the features of malignant endocarditis that Dr. Osler has attempted to arrange them into groups. In the first group are placed those cases in which the endocarditis is merely a part of a septic or pyæmic state, resulting from an external wound, a puerperal process, or on acute necrosis, about 18 per cent. of the doctor's cases being of this nature; the septic cases do not strictly come within

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the province of the physician, but must be taken into account in a description of the disease. These cases arise through the venous system.

In the pyæmic cases, the clinical features are of a decided pyæmic type, the metastatic lesions are in the territory of the arterial system and have their source in the heart. Two varieties of these cases may be made out: 1. Those of ordinary pyæmic type; 2. Those marked by a singularly regular intermittency of the pyrexia. The cases may resemble so closely cases of quotidian or tertian ague as to make it almost impossible without a necropsy to differentiate, though the absolute failure of quinine may cause one to question the diagnosis of malarial trouble. The typhoid type is, however, by far the most common The main feature is the irregular character of the fever, but sometimes the cardiac affection being masked, the course of temperature may so stimulate typhoid as to make diagnosis difficult, except after death.

In the second group are placed the cardiac cases, that is, those occurring in patients the subject of valve-disease, who suddenly show evidence of fresh endocarditis, accompanied by febrile symptoms. These cases may present features of the pyæmic, typhoid or cerebral types, in some may be intensely acute, in others mild and chronic. In the third group are the cerebral cases, in which the earliest observed symptoms, or the most marked, are cerebral or cerebro-spinal. Some are first seen in coma, or the symptoms may be those of meningitis.

The course of endocarditis presents many variations, some cases running their course in a week, others lasting even two or three months, though rarely prolonged beyond four or five weeks.

As regards diagnosis, this is frequently so difficult that many skillful diagnosticians have been unable to discover the trouble until post mortem. In the group of cardiac cases the diagnosis is easy enough, the irregular type of fever taken with the physical signs being sufficient, but in other cases, the cardiac affection not being apparent, it may be difficult to differentiate from quotidian or tertian, intermittent, from typhoid, typhus, cerebro-spinal meningitis or even hæmorrhagic small-pox. In pyæmic cases, the diagnosis must be made between ordinary septic infection from a wound and auto-infection from a primary endocardial inflammation.

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In determining the etiological relations of malignant endocarditis, Dr. Osler has gone over the records of 209 cases. 37 of these occurred in connection with traumatic and puerperal pyæmia, in 45 no record of previous disease, in 127 cases there was a possible connection with past or existing disease. Middle life gives the greatest number of cases, young children being rarely victims; of 160 cases (exclusive of traumatic and puerperal), 99 were males, 61 females. Debility and addiction to drink predispose; sclerotic valvulitis is a very important etiological factor. Of the 127 cases secondary to other disease, in 53 there was a history of rheumatism, past or present, in 54 the attack was associated with pneumonia, diphtheria was rarely associated, with dysentery a few cases, in the eruptive fevers a few cases, and even in the course of malarial fever a few cases have developed.

With regard to pathology, Dr. Osler speaks with due caution, not allowing himself to be carried away by the attractiveness of the theory. Accepting as a plausible explanation the mycotic pathology of malignant endocarditis, he yet feels hesitation in urging it. We do not yet know with sufficient accuracy the frequency of occurrence of the microbes in the disease, we want to know the varieties of microbes in secondary endocarditis and their relation to those of the primary disease; and, thirdly, we are only on the threshold of inquiries concerning the culture of these organisms, the microscopic characters of their growth and the possible experimental production of endocarditis.—*New Orleans Medical Journal.*

Treatment of Hiccough by Compression of the Phrenic and Pneumogastric Nerves.—When we examine the different methods of treatment of hiccough called *idiopathic*, one is surprised to find scarcely anything else advocated than a number of remedies popular as well as empiric, such as strong compression of the wrist, and sudden fright, swallowing a large quantity of cold or acidulated water, compression of the chest or pit of the stomach, etc. It is rather odd that, in the treatment of this spasm of the diaphragm, a therapeutic action upon the nerves which preside over its function or influence it in a reflex manner has been so little sought after—we refer to the phrenic and pneumogastric nerves. It is true that the malady being as a rule benign, the above treatment has usually sufficed. However, T. Schortt, Duchenne, Bouchut, and Tripier, each advocate a method in which they had had in view an action on the nerves which appeared to them to be involved. The first three wished to act on the phrenic,

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A. Tripier on the pneumogastric. The Scotch physician, Thomas Schortt, successfully applied a blister over the phrenic nerve; Bouchut extols the hypodermic injections of morphia in the course of this nerve. Duchenne uses galvanism of the phrenic; the continued current is used by A. Tripier, who advises its application, "the positive pole to the epigastrium, the negative to the front of the neck, in the line of the pneumogastric."

It will be noticed that, whatever the theoretic idea may be that has influenced the choice of one or the other of these nerves, the therapeutic application always involves both. The reason for this is the anatomy of the parts. After referring to the anatomical relations of the two nerves in the neck and to the diffusible nature of electricity applied the surface, the writer goes on to say: But in a malady usually so mild, and which as a rule lasts but a few minutes or hours, when it is not symptomatic of a serious disease, such as peritonitis, intestinal obstruction by internal strangulation, etc., such a condition, I repeat, where hiccough is styled *idiopathic*, the treatment employed ought to be as simple and easy as possible. It is true that if one can consider as simple the use of electricity, blisters and hypodermics, one ought to observe that they have been only resorted to where empirical means have failed. We must find, then, a means at once easy of application and effective; such is the treatment of hiccough by digital compression.

It requires no instrument; it is readily applied even by the patient. We have seen just now that four or five centimetres of the inferior clavicular portion of the sternocleidomastoid muscle lie directly over the two nerves. This is the part we select, guided by the pulsations of the carotid. The thumb and index finger are used on either side symmetrically, applying pressure sufficiently strong to cause the spasm to disappear. One or two minutes as a rule, sometimes less, are sufficient; meanwhile the patient's head must be kept immovable. In our method, as in those that we have cited, the therapeutic action affects equally both nerves.

It follows that if the hiccough arises from the stomach, the pressure which effaces or diminishes the reflex action of the pneumogastric will stop the spasm during the time it is reflexly excited and often even afterwards. If, on the other hand, the cause arises directly from the influence of the phrenic, the calmative action of compression is equally manifested. Whatever may be the pathogeny of

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hiccough and the therapeutic mode of action of the digital compression, the result is nevertheless remarkable. We have rarely seen this method fail in idiopathic hiccough. Once, however, in a young hysterical girl, who had suffered from hiccough for two days, compression far from calming the spasms, each time it was applied, rendered them on the contrary more frequent. In hiccough symptomatic of a severe general disease we have never successfully used compression. We would in no wise discourage experiments in this line, having only used this method five years.—*Dr. Grognot in Bulletin General de Therapeutics, R. Z.*

Hemorrhage During Sleep.—On various other large subjects Dr. Wilks has fertile suggestions to offer. He has spent some time and trouble in confirming his first impression, which was originally judged to be heretical, that hæmoptysis occurs more often in the night after some hours of sleep, than in the day after some hours of exertion. He does not claim to give a full explanation, but remarks that the helps to the circulation given by the respiratory movements is certainly less by night than by day, so that tension might in that way possibly be raised; but, at any rate, he does not hesitate to draw the inference, which is of no little importance to many who are suffering from a tendency to hæmoptysis, that they need not be frightened into preserving that harassing and absolute quiet which is devised to guard against a recurrence of hemorrhage. Certainly Dr. Wilks' inference is supported by some of the many methods of cure, especially in the high Alps; but if it were acted upon in all cases, though it might possibly be justified on the whole by its relief of perpetual discomforts, yet it would occasionally bring a responsibility on the medical adviser from which he would be glad to be free, for the occurrence of fatal hæmoptysis during exertion is certainly not unknown. The rupture of aneurisms and of blood-vessels in the brain is also more frequent by night than by day, and the conditions controlling the matter deserve some of the more elaborate care that Dr. Wilks claims for them. And there are many other observations of interest for which we have to thank Dr. Wilks, and for which we most gladly refer our readers to the address itself.—*British Med. Jour.*

Rupture of the Heart.—Dr. H. Nelson Hardy thus writes in the *British Med. Jour.*, April 4: Cases of spontaneous rupture of the heart in young persons are sufficiently rare to deserve recording. In the following case, the patient, a young woman, aged nineteen, had

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been apparently healthy when she went to bed on the night before her death. She had had an attack of rheumatic fever when fifteen years old, but had not lately complained of feeling ill. She had no fainting attacks, nor was there any arcus senilis present. A slight loss of memory had been noticed quite recently.

On March 17, 1885, a little before 7 A.M., I was sent for to see the patient, who was said to be dying. I found her lying in bed on her back, insensible, almost pulseless, her eyes closed, and pupils widely dilated. In a quarter of an hour after my arrival, the heart had ceased to beat.

On March 18th, thirty-two hours after death, the necropsy was made. The body was well nourished, and there were no marks of violence. The membranes of brain were adherent to the skull-cap; the brain substance was healthy; and there were between one to two teaspoonfuls of serum in each lateral ventricle, On opening the pericardium, there was seen on the anterior surface, near the apex, a slit fully one inch and a half long, which led into the left ventricle, and extended irregularly upwards towards the septum. Slight pressure on the heart caused fluid blood to pour out through this opening into the pericardium, in which there was previously about an ounce of colored serum. Several of the chordæ tendineæ were also found ruptured, and the aortic valves were incompetent through old adhesions. The lungs were congested, but not diseased; the liver was adherent to the diaphragm; the stomach was healthy, and contained partially digested food; the other organs were healthy, and the uterus unimpregnated. The special points of interest in the case are the youth of the patient, and the almost total absence of any indication, during life, of fatty degeneration.—*Compendium of Med. Science.*

Baths for Rheumatism.—Turkish baths are now prescribed in New York for those forms of rheumatism resulting in deformity of the joints. The baths are taken twice a week and for half an hour's duration. Several ladies who have passed through the alkaline treatment find that these baths afford them great relief.

The medicine which seems to give the most satisfaction is aqua ammonia, in twenty drop doses, three times a day, in a half tumbler of cold water, the bicarbonates of potassa and soda are objectionable, because they are liable to produce a skin disease resembling herpes. —*Med. Sum.*

Small-pox in Montreal.—The number of cases of small-pox in Mon-

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treal during the past month has been considerably increased, and a serious epidemic is threatened. The disease is chiefly confined to the French-Canadian population, and its prevalence and malignancy is owing to the fact that as a class they persistently refuse the protective influence of vaccination. The number of cases among the vaccinated is comparatively small, and the mortality is very light. There is no better evidence of the protective power of vaccination to be found than that furnished by the statistics of small-pox in Montreal.

Clinical Significance of Fibrinous Exudations upon the Mucous Membrane of the Upper Air-Passages.—Dr. F. H. Bosworth, in a paper on this subject read before the American Laryngological Association (*New York Medical Journal*, May 24, 1884) sums up the points on which he would place special emphasis as follows:

1. A fibrinous exudation which occurs in the crypts of the follicles of the faucial or pharyngeal tonsil, or of the mucous membrane of the lower pharynx, has no tendency to extend, and characterizes a disease which is self-limited and which involves no dangerous tendencies.

2. A fibrinous exudation which occurs upon the surface of the tonsil, or of the mucous membrane of the fauces, constituting a croupous membrane, so-called, presents gross appearances by which it can be unmistakably recognized. It is easily detected, and can be peeled off from the parts beneath without lacerating the tissues. It is a white, clean, healthy-looking membrane, and presents every aspect of a living tissue.

3. A croupous membrane in the fauces of an adult marks the existence of a disease, which, while being undoubtedly a blood poison, is still a self-limited affection, and one which involves no danger to life.

4. A croupous membrane forming in the fauces of a child marks the occurrence of the same disease as a croupous membrane in an adult; but in the child there is the additional danger of a new centre of development occurring in the larynx, where it may involve the greatest danger to life, but mainly as a mechanical obstruction to breathing.

5. A diphtheritic membrane developing in the fauces marks the occurrence of a disease which is dangerous to life, not only from primary and secondary blood-poisoning, but also from the tendency to the development of the same morbid process in the larynx.

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Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

Bacterio-Therapic Experiments.—Based upon the principle, that some microphites in contact with some pathogenic scizomicetes, completely destroy them, either by usurping their means of sustenance or by otherwise altering the conditions propitious to their development, Dr. Catani has instituted a system of experiments, which if elucidated by a large plurality of facts, will undoubtedly revolutionize our present therapeutics.

His first aim was the annihilation of the bacillus tuberculosus of Koch by the bacterium terms. After having established the innocuity of this bacterium in animals through its introduction into their system by inoculation, ingestion, inhalations, rectal and intravenous injections, he chose for his first experiment upon man, a case of tuberculosis pulmonalis as follows: A woman 42 years of age, whose father died of consumption, presenting all the physical signs of a vast cavity in the superior lobe of the left lung, with evening paroxysms of fever, considerable emaciation, cough and purulent expectoration—containing elastic fibers and numerous bacilli of Koch. The sputa inoculated in animals determined tuberculosis.

After infructuous treatment by diverse other means, on the 4th of May inhalations of liquid nutitrum gelatin, diluted in sterilized meat broth containing a pure culture of bacterium terms were administered through an ordinary atomizer. The expectoration soon diminished, afterwards ceased altogether; the bacilli decreased in number and soon were completely absent; in their stead, appeared in profusion, in the sputa, the bacterium terms.

The fever subsided, the patient gained flesh and the animals inoculated with the sputa deprived of the bacillus of Koch, gave no tuberculous results.—*Prof. Catani, of Naples.*

Hiccoughs Treated by Pressure of the Phrenic and Pneumogastric Nerves.—Numerous means are resorted to for the arrest of hiccoughs, some thoroughly empyric and others scientific. Pressure of the phrenic and pneumogastric nerves, which preside to the functions of the diaphragm or excite it in a reflex manner, is one of the scientific means employed. The opinion of the authorities as to which of the two nerves must be acted upon, is divided; Duchenne (de Bologne)

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and Bouchut advocate, each by a special process, the action upon the phrenic nerve, and Tripier, that upon the pneumogastric. Whilst Duchenne employs, with success, galvanism and a fly blister over the traject of the phrenic nerve, in the neck, Bouchut recommends hypodermatic injections with morphine and Tripier applies the continuous current with the *anode* on the epigastrium and the *cathode* on the neck, in front, over the traject of the pneumogastric. In the midst of this chaos, the practitioner is unable to discriminate which of the two nerves should be aimed at. This problem has been, however, solved, thanks to Dr. Grognot of Melly, by his suggestion to use digital pressure on a point where both the phrenic and pneumogastric run in close proximity. This elective point is situated from 4 to 5 centimeters (1½ to 2 inches) of the clavicular portion of the sterno-cleido-mastoid muscle. He proceeds as follows: After having ascertained the position of the primitive carotid, the thumb is applied, encircling the neck, over this spot, the index finger pressing upon the opposite side. In this manner, a sufficient pressure is exercised over both nerves to arrest their spasmodic action, which is overcome in one to two minutes, and sometimes less. The head must be steadied during the operation, to preserve the pressure on the same plan.

In simple or idiopathic hiccoughs, these means are successful; but they fail when they are symptomatic of a low condition of the system.

Bromine in Diphtheria.—This medicament employed by Schulz and Gottwald, modified according to age and intensity of symptoms, brings good results applied to the buccal cavity and pharnyx.

These authors propose the following formula:

℞ Bromi. Purif. } aa 50 centig. to 1 gram.
Pot. Brom. }
Aq. Dist. 200 gram.

M. S.—Apply every 2 or 3 hours to the mouth and pharynx by means of a probang and follow it by an inhalation according to formula below, through a paper cone open at both ends, a sponge saturated with it being placed at the wider end:

℞ Bromi. Purif. } aa 60 centig.
Pot. Brom. }
Aq. Dist. 300 gram. M.

Benzoate of Sodium Against Summer Diarrhœa of Children.—Dr. Guasta considers the summer diarrhœa of children a zymotic disease owing to the presence of a special microbe provoked by a faulty diet; a bad hygiene, and elevated temperature being predisposing causes.

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In cases dating only from 24 to 30 hours, in children from six months to two years of age, he employs the benzoate of sodium exclusively, preceded by a purgative (calomel or jalap). He administers the first two days from 4 to 6 gram (3i to 3iss) per day, dissolved in 100 gram. (ʒiii) of water. The third day a dose of magnesia is administered, followed by the benzoate sodium as before. The diet is restricted to lemonade and a few spoonfuls of generous wine. Milk and bouillon are not allowed, but suckling children are permitted the breast about four times in the 24 hours.—*Jour. de Med.*

Cholera Vaccinia.—Some interesting and important experiments with attenuated cholera virus have been made by Dr. Ferran of Barcelona. Two medical men, Drs. Seranana and Jacques, were inoculated with the virus. At 5 P.M. the former was inoculated with half a cubic centimetre of the fluid in each arm. At 7:30 he began to feel severe pain in the backs of the arms, preventing their free action. This pain was subject to temporary exacerbations, and at 11 P.M. pyrexia commenced—we are not told whether the thermometer was used—manifested by malaise, a burning heat, an irregular pulse of 100 per minute, insomnia, and slight headache. He was, however, able to attend to his practice the following day, though the symptoms continued till 8 o'clock in the evening, when they suddenly disappeared. Dr. Jacques was inoculated with half a cubic centimetre of the same fluid in one arm at 4 P.M., and experienced the same symptoms as his colleague, with the addition of a slight rigor and some nausea.

An Adult Hermaphrodite.—Prof. Dohrn has described, in the *Archiv fur Gynakologie*, vol. xxii, a remarkable case of extreme hypospadias in a male aged thirty-one, who had been mistaken for a female at birth, christened, and brought up as a girl, and married to a man for six years. After marriage, frequent irregular hemorrhages from the genitals took place, and coitus was extremely painful, and followed by severe pain in the hypogastrium. The hermaphrodite consulted Dr. Dohrn, who found that the external labia contained a pair of bodies each resembling a well formed testicle and epididymis, and a vas deferens could be traced to the external abdominal ring on each side. The labia minora were quite of the normal female type, but united anteriorly to form a large prepuce to an organ of the size of an infant's penis. A groove ran from the glans along the under side of this penis to the orifice of the urethra, which was very wide, having served for intromission; and vascular growths, the cause of the

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hemorrhage hung from it. On the posterior border of the urethral meatus were three distinct canals; into the left and the median canals a fine bristle could be passed to the extent of half a centimetre, into the right canal it could be introduced more than double that distance. Dr. Dohrn believed that these canals were the prostatic vesicle and the ejaculatory ducts. No prostate, nor uterus, tubes, or ovaries could be detected on rectal examination.

Class-Room Notes.—From the *College and Clinical Record.*—For a boy aged eight years, with chorea, limited to the voluntary muscles, Prof. Bartholow ordered that the child be kept from school. A pill of the iron iodide was given ter die, also liq. potassii., gtt. iij, at first, then soon to be increased to gtt. v ter die, and again reduced to gtt. iij ter die.

For migraine in a woman aged forty-five, the attacks of pain occurring every two weeks, Prof. Da Costa advised a diet from which meat should be excluded, also ʒ j of Rochelle salts in the morning, with liq. potassii arsenitis, gtt. iij–v. ter die. The oleate of aconitia was directed to be rubbed in over the seat of pain.

Prof. Bartholow says that itching of the skin, from any cause, can be allayed by sponging the patient with:—

℞ Acid carbol..... ʒ ij
Glycerini..... ℥ j
Aquæ rosæ ad..... ʒ viij
M. Sig.—Lotion.

For superficial neuralgia, the following will often be found of benefit (Prof. Bartholow):

℞ Ol. caryophylli.....
Ol. gaultheriæ.....
Ol. thymi.....aa.. ʒ j
Tinct. benzoini.....
Tinct. cinnamoni.....aa.. ℥ iv

For chronic ulcers of the leg which resist various plans of treatment, Prof. Bartholow advises that the surface and surrounding skin be blistered, to be followed by the application of a poultice. This done, use the following:—

℞ Plumbi nitrat..... ʒ j
Ung. petrolei (cosmoline)..... ℥ j

To a granulating surface, Prof. Gross applies the following:

℞ Acidi nitrici..... ʒ j
Pulv. acac..... ℥ ss
Aquæ..... O j

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Or

℞ Ung. hydrarg. nit..... ℥ j
Adipis benzoat..... ℥ x M

These are used to promote rapid ciatrization.

A young woman—a seamstress—was presented to the class by Prof. Bartholow, suffering from severe headache and anæmia. Prof. B. said it was not wise to give the bromides in such a case, but better the phosphate of iron, quinine and strychnine, with well-regulated outdoor exercise. Diet—meats, and not too much starchy matters. Inunctions of fat at night, after a warm bath, are of value. "The body of an adult will take up half an ounce of fat."

An aggravated case of gastric catarrh, with gastralgia, was before the clinic, for which Prof. Da Costa advised the following treatment: Diet—milk and soft-boiled eggs, a little lime water to be added to the milk. Between meals she is to take bismuthi subnitras, gr. xv. At night:

℞ Aloes..... gr. ¼
Ext. belladonnæ..... gr. 1-12
M. Sig.—In pill.

For hystero-epilepsy occurring in a young girl seventeen years old, Prof. Da Costa prescribed:—

℞ Acid. hydrobromic. dilut..... ℥ ss
Sig.—Bis die.

Constipation being a marked element, she was directed to take a pill consisting of—

℞ Aloes..... gr. 1-6
Ext. belladonnæ..... gr. 1-12
Capsici..... gr. ½
M. Sig.—At night.

For a case of syphilitic lobar pneumonia, Prof. Da Costa advised—

℞ Ammonii iodidi..... gr. v
Spirit. ammonii aromat..... gtt. xv
Elixir. simplicis..... ℥ ss
Aquæ..... ad.. ℥ j
M. Sig.—Ter die.

To this was added a pill consisting of—

℞ Digitalis..... gr. ss
Quininæ sulph..... gr. j
Ext. opii..... gr. ¼
Ext. ipecac..... gr. ¼ M.

In cervical catarrh, iodine in the nascent state is used by Prof. Parvin. First apply to the parts concerned the following:—

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℞ Potassii iodidi..... grms. x (℥ijss)
Potassii iodat..... grm. j (gr. xv)
Aquæ destillat .....grm. j (—50) (f ℥ ijss)

After this has been thoroughly applied, then use upon the same surface, so as to liberate the iodine--

℞ Acidi citrici..... grms. x (℥ ij ss)
Aquæ destil..... grm. j (f ℥ j ss)

A man suffering with hypochondriasis, with intestinal torpidity as a probable cause, was given, by Prof. Bartholow:—

℞ Euonymin..... gr. iij
Ext. colocynth. comp..... gr. ij
Hydrarg. chlor. mitis. ..... gr. j

M. et pil. No. 1. Sig. —To be taken at night; and a pill each night after, of—

℞ Physostigmat.....
Ext. nucis vom.....
Ext. belladonnæ..... .....aa.. gr. ¼

For a case of psoriasis, Prof. Da Costa advised the persistent use of the following:—

℞ Acidi arseniosi..... gr. 1-30
Capsici..... gr. ½

M. Sig.—Ter die.

As a morning laxative, Rochelle salt, ℥ ij. The diet must be varied, consisting chiefly of fruits and vegetables. No salt meats. The local treatment: Get rid of the scales by a poultice, then use—

℞ Potassii carb..... ℥ j
Aquæ..... O ij

M. Sig.—Apply frequently.

Several cases of membranous enteritis were shown in Prof. Da Costa's clinic. The treatment consisted in keeping the fecal accum ulation in a soluble state by—

℞ Magnes. sulph..... ℥ ij
Ferri sulph..... ℥ ij
Aquæ..... O ij

M. Sig.—Take every morning. ℥ ss.

Also—

℞ Liq. potassii arsenitis..... gtt. ij
Tinct. ignat. amaræ..... gtt. vj
Tinct. cinchon. comp..... ℥ j

M. Sig.—Ter die.

Addison's Disease.—At the meeting of the Berlin Medical Society on the 25th ult., Dr. Jurgens showed specimens obtained from two cases of Addison's disease. One exhibited the typical characters of the

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adrenal affection, together with caseous broncho-pneumonia; the other was a case which had been under observation for some time, presenting the clinical symptoms of morbus Addisonii; but it was a case in which a large aneurysm of the abdominal aorta had compressed the splanchnic nerves. The statement was made that in all cases of Addison's disease these nerves are in a state of grey degeneration, and that cases in which the adrenals are diseased, without any discoloration of the skin or other clinical symptoms of Addison's disease, these nerves are not involved. The account (*Deutsch. Med. Woch.*, March 5th), is too meagre to allow of any criticism upon this communication; but it is to be hoped that full details (clinical as well as pathological) will be published.

Prof. Virchow on Croup and Diphtheria.—In a speech recently made at the Berlin Medical Society, Prof. Virchow restated the views he has long held upon the pathological dissimilarity of croup and diphtheria; and the statement from such an authority must command attention, although it is hardly consonant with conclusions which have been mainly accepted in this country since the report of the Royal Medical and Chirurgical Society's committee was published. Virchow briefly reminded his hearers that the term croup, originally a clinical phrase expressive of a prominent symptom of acute laryngeal affections, was first applied in a pathological sense by Rokitansky to all pseudo-membranous affections of mucous membranes, and extended by him to visceral inflammations characterized by fibrinous exudation. In 1847 Virchow, in the first volumne of his *Archiv*, pointed out the anatomical distinctions between a croupous and a diphtheritic inflammation of mucous membranes, the former being an exudation upon the surface of the membrane, the latter a necrotic process, in which the false membrane is composed of the exfoliated tissue. At that time he knew nothing of micro-organisms in connection with diphtheria, but he had observed masses of granules, as he then supposed of albuminous nature, in the substance of the diphtheritic membrane, which were never present in the croupous exudate. Nor has he ever been enabled to admit that all cases of fibrinous laryngitis and tracheitis are due to diphtherial poisoning, and he had preparations in which there was not the least evidence of diphtheria. His contention was that the diphtheritic process invariably led to destruction of the mucous membrane, and this recognition of an anatomical difference between croup and diphtheria was, he thought, of prime importance in regard to

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prognosis after tracheotomy, for in the one case a detachment of the false membrane did not, as in the other, leave any ulcerative lesions behind. In support of this he showed preparations of diphtheritic laryngitis and tracheitis with ulceration.

Obstetrics and Gynecology.

Edited by E. P. MURDOCK, M.D., 179 South Sangamon St.

Treatment of Abortion at the Fourth or Fifth Month, with Retained Placenta. —Dr. G. R. Southwick of Boston, (in the *Am. Jour. Obs.*) gives us a very interesting paper on this subject in which he points out the change in the medical fraternity during the last few years on this subject from the expectant treatment to the radical plan of dilating the cervix and removing the secundines immediately, and very pertinently puts the query as to whether or not the pendulum of progress might not have swung too far to the opposite side from the old but easy expectant idea. He says when labor takes place at full term the uterus contracts away from the placenta, which is a more contractile body and thus separation takes place. The uterine muscular tissue continuing in this contracted state constricts the sinuses and hemorrhage is prevented. Thrombi form back of these constrictions and when the uterus partially relaxes in twenty-four hours, serve to plug the vessels and in turn also prevent hemorrhage. But when abortion takes place in the middle of gestation, the muscular tissue of the uterus has not reached that degree of development and becomes ready for the metamorphosis which takes place at full term. The surface contraction is less in proportion i.e. there is less contraction to the square inch of surface and consequently separation of the placenta is less likely to follow, both for this reason and on account of its firm attachment. Thrombi therefore do not form so rapidly and hemorrhage is liable to ensue though not so severe as under similar circumstance at term.

In some rare cases small portions of adherent placenta become organized and a fibroid polypus hydatidiform mole develops. In nature's method of removal the blood vessels are closed behind the adherent portions, the placental tissue gradually disentegrates and is cast off; here another element must be considered—the danger of septicemia.

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Retention of a part or the whole of the placenta is, therefore, liable to give rise to one of the following complications:

1. Hemorrhage either immediately and profuse or remote and become continuous in small quantities.
2. Septicemia.
3. Some intra-uterine growth.

The aim of treatment is to prevent or forestall them, and may be active or conservative. Active treatment consists in the immediate removal of the secundines in every case, either by the finger, placental forceps, or curette. There is good reason to fear the results of traumatism, as inflammation of the uterus and cellular tissue, or even perforation of the uterus especially when performed by an unskillful hand, which is not infrequently the case. Very often the removal of placenta tissue is tedious and accompanied with considerable hemorrhage.

If no urgent symptoms be present the Doctor thinks it is well to see what conservative treatment will do, or plug the vagina for a few hours and often on removal of the tampon the retained secundines are easily delivered.

It sounds very easy to read that, to remove the placenta, the uterus is to be pressed down in the pelvis with one hand externally while the forefinger of the other enters the uterine cavity, passes up over one side of the placenta and down on the other so as to hook it down and extract it from the uterus, but it is a very different thing to do it.

The pelvic tissues being tender and painful, the abdominal walls being quite thick, the uterus being high up and the os contracted and small, the operator's fingers being short, or when the uterine cavity is reached the attached placental tissue being high up in one horn of the uterus, extremely slippery and persists in gliding from beneath the finger and yet does not come away, any or all of these complications, soon exhaust the Doctor's strength, the patient's good nature and forbearance, and lays the foundation for pelvic inflammation besides endangering the patient to the introduction of septic germs during the process of this manipulation.

But if any of the three complications mentioned above should ensue, then of course there would be no alternative other than active interference and emptying the uterine cavity.

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To prevent hemorrhage he suggests the tampon as temporary means, as after the most careful plugging the plug becomes compressed and blood escapes around it as before. It is important to remember that no portion of the tampon should protrude between the labia as it would almost certainly be forced out by muscular action. The plug may extend into the cervix. It serves the double purpose of promoting uterine contractions and expulsion of the secundines, as well as temporary control of hemorrhage; and avoids the necessity of radical measures unless symptoms of sepsis ensue.

The next danger, and the most to be dreaded is septicemia. As this most probably is a result of the introduction of septic germs from without in some manner, by the hands, or instruments or air, it goes without saying that the physician should never attend such cases immediately after visiting a case of scarlatina or other zymotic diseases without the most rigid antiseptic precautions. When symptoms of septic infection present themselves, they should be treated the same as septic fever from any other origin; rigid cleanliness by intra-uterine douche, control of temperature, etc.

The third complication is so rare it only needs to be referred to as a sequela and treated as an independent subsequent incident, when menorrhagia and metrorrhagia require the use of the curette, placental forceps or sometimes the ecraseur.

The paper very fairly discusses the subject and fairly shows that there is fair grounds for discussion between the radical means and the expectant plan, and arrives at the sensible conclusion of the old German proverb: "The middle road is the better road, and only the careful physician can decide which means to adopt in a given case." —[ED.]

Dr. J. B. Hunter in a report on pyo-salpinx, gives some very interesting points in differential diagnosis and says there are certain symptoms and physical signs, by which these cases can be distinguished. The symptoms common to suppurative disease of the Fallopian tubes are: Severe pain two or three days before menstruation, located in the affected side and running down the corresponding limb; constant pain during the menstrual period; comparative freedom from pain for a week or ten days after its cessation; profuse menstruation and sometimes constant, though slight metrorrhagia; a discharge of pus (having frequently an offensive odor), after the flow has ceased.

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The physical signs are: A mass is found posterior to the uterus, often so hard as to be mistaken for a fibroid tumor; the uterus is large, globular in shape and generally movable; when palpated after a period, the organ appears to be smaller than before and the tumor behind feels softer. There is often so much general tenderness around the uterus that an accurate examination is only possible during anæsthesia. In cases of hydro-salpinx (which it is important to differentiate from those of pyo-salpinx), the tubes are often much larger, and are as a rule, freely movable, not being adherent to the uterus.

Another point of difference between the two is that, while there may be considerable amount of local pain in hydro-salpinx, there is not so much general disturbance as in suppurative inflammation of the tubes. Doran in his recent work on the ovaries and tubes says: "There can be no doubt that some of the most intractable cases of pains in the pelvic and iliac regions often attributed to other causes, are really due to disease of the tubes. The pain due to ovarian disease uncomplicated with tubal disease, is of a more intermittent character and is generally referred, not only to the affected region, but also to the breast on the same side, and is very commonly accompanied by nausea, a symptom which is not noticed when the tube alone is affected. It is important to distinguish between catarrhal and purulent affections of the tube, because the treatment is radically different; cases of pyo-salpinx go on rapidly from bad to worse, and probably never recover without surgical interference, while simple hydro-salpinx not complicated by ovarian disease is not dangerous to life, and may remain stationary for years."—*N. Y. Med. Jour.*

Prof. A. Reeves Jackson sends reprint of his excellent paper on "Vaginal Hysterectomy for Cancer," in which he very clearly proves that the operation is not only devoid of benefits, but is injurious and unjustifiable. He offers the following conclusions:

1. Any operation for cancer, which does not completely remove the disease will be followed by recurrence.

2. During life, the diagnosis of the extent of cancerous disease originating in any part of the uterus is at present impossible, hence no operative procedure can afford to guarrantee a complete removal.

3. In view of this necessary doubt, no operation is justifiable, which greatly endangers life, provided other and safer methods of treatment are available.

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4. Vaginal hysterectomy has sacrificed the lives of more than one-third of those who have been subjected to it—the mortality of the operation, when done by those of the greatest skill and experience being over 36 per cent.

5. Other methods of treatment attended by not more than one-sixth or one-fourth the mortality of vaginal exterpation, are equally as efficient in ameliorating the symptoms and retarding the progress of the disease; and they have been followed by as good or better ultimate results, hence they should be preferred.

6. Vaginal hysterectomy does not avert or lessen suffering, it destroys and does not save life. It is therefore, not a useful, but an injurious operation, and being such, it is unjustifiable and ought to be abandoned.

Dermatology.

Edited by HENRY J. REYNOLDS, M.D., 2200 Michigan Ave.

Treatment of Carbuncle by Oleate of Morphia.—In the course of a paper read before the Indiana State Medical Society, in 1885, by Dr. James F. Hibberd, of Richmond, Ind., and published in the *Indiana Medical Journal*, May, 1885, the author makes the following remarks:

At the late meeting of the American Medical Association in New Orleans, Dr. L. D. Bulkley, a distinguished dermatologist, of New York, read the first paper before the section on Practice of Medicine, entitled "The Treatment of Carbuncle Without Incision." As his paper will soon be published,* it is not my purpose to rehearse his views here, but to simply say that he announced that the treatment of carbuncle by the orthodox crucial incision, poultices, other hot applications and ointments, had been so unsatisfactory that for several years he had abandoned them all and substituted soothing applications of special mixtures, the composition of which he detailed, for the most part applied on cotton or the pile side of patent lint, and paid particular attention to the constitutional treatment, insisting upon the value of supporting measures, tonic medicines, and the sulphide of calcium as a means of limiting suppuration. Dr. Bulkley detailed a number of cases, some of them quite severe, which he had managed under his new views with much better success than formerly, though his patients still went through the usual phases of the malady,

* See Jour. Am. Med. Ass'n, p. 542.

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but not occupying the full time period of seven weeks as of old, nor did they suffer the former serious local pain, nor the general constitutional depression.

As I had had a new experience in the local treatment of these painful and exasperating tumors within the last twelve months with a preparation to which he made no allusion, although exactly in line with his advanced views of the best management, I ventured, in the discussion of the paper, to make a plain statement of my experience in this behalf, and while it is not of sufficient extent to lay claim to an established treatment, it seems to me of sufficient importance to repeat here, that practitioners may make trial of the remedy, and determine whether my cases were happy coincidences or a substantial advance of our knowledge in the local treatment of carbuncle.

The application I desire to call attention to is the oleate of morphia, and to illustrate my experience I will present the details of the first and the last cases where I made use of it:

On the 30th of April, 1884, T.N., an active business man of general good health, about sixty years old, applied to me for a painful swelling on his neck to the left of the ligamentum nuchæ, a little below the line of hair.

Telling my patient that he had carbuncle, and was likely to have several weeks of great local suffering and much general depression, I gave him some oleate of morphia, with careful instructions how to apply it, expressing the hope that it would do something to mollify the pain if nothing more, and this I did because of my experience in alleviating other painful conditions of the skin and subcutaneous tissue with this preparation of morphia. It was also to be applied to the nodules forming near the principal swelling. The patient returned the next day, and quite to my surprise and gratification, stated that nearly all pain had ceased in the large tumor, all was gone from the smaller ones, and the soreness and stiffness of the neck had greatly diminished. On examination the smaller tumors were shrunken and no longer irritable, and the larger one had lost something of its boggy feel, was apparently smaller, was but slightly sore, and the skin over it was more natural in appearance. The application was continued, and at the end of three days all pain and tenderness had left the neck, the smaller tumors disappeared, and the larger ones had the characteristics of a calloused indurated swelling

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under the skin, about half the dimensions of the original tumor, and this was absorbed in about a week or more.

Two or three months subsequently the patient had another disturbance near the same spot, beginning in an irritable pimple as the former one had begun, but a few applications of the same remedy applied by my direction arrested all further development.

On the 24th of April, 1885, Mr. J. W. G., aged eighty-six years, sought my advice for a tumor on the back of his neck, to the right of the ligamentum nuchæ, which was giving him much pain and anxiety. It proved to be a carbuncle an inch and a half in diameter, with a point of superficial suppuration on top. An inch below the main tumor was a smaller one, an irritable pimple such as the larger one was in the beginning.

The swelling was of several days' standing, and a part of the skin covering it so inflamed that I feared the oleate of morphia could not be used with the success that otherwise I should have hoped for. However, I gave him the preparation, with instructions for its diligent and proper use, but explained to him why it might fail, and advised him, if he had no relief after a fair trial, to consult another practitioner, as I should leave for New Orleans on the afternoon of the next day. But at noon the next day the old gentleman reappeared at my office, with a smiling countenance, to give me some good news, as he averred, before I left, stating that the soreness of the tumor was nearly gone, the stiffness of his neck but trifling, and the pain so promptly relieved that he had had a good night's rest, the first of the kind since the swelling began. On examination the soreness of the smaller tumor was removed, and that of the larger one greatly diminished, and its appearance and feeling altered for the better, while the superficial point of suppuration was discharging but little and the surrounding inflammation of the skin greatly subdued. Treatment was directed to be continued, and when I returned and examined the seat of disease ten days later, there still remained a small indurated nodule under the skin, but no soreness, no pain, nor other inconvenience, and to this condition it had been steadily approaching since my last previous examination.—*Virginia Med. Monthly.*

Recent Advances in Dermatological Therapeutics.—Under this head Frederick W. Putnam, M.D., of Binghamton, N. Y., contributes to the August number of the *Jour. of Cutaneous and Veneral Diseases* the following interesting article:

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It is undoubtedly the general verdict of every intelligent physician in general practice that the treatment of cutaneous diseases, as a whole, is not generally as satisfactory, either to himself or patient, as other departments of practice. The principal reason for this is the little attention given to the subject by the general practitioner.

While I may not be able to instruct you, yet I hope to gain a sufficient amount of your attention to awaken an interest and stimulate a desire for investigation in this department of the practice of medicine.

The methods of treatment which I have outlined are a review of some of the more recent advances in cutaneous therapeutics.

It is not to be understood, however, that the remedies mentioned in this paper are recommended as the best are only remedial agents to be used in each instance in the management of the various diseases under consideration to the exclusion of other and well-recognized plans of treatment, but as supplementary thereto.

I wish to direct your attention, first, to a class of preparations but a very few years ago introduced into cutaneous therapeutics, and known by the general designation of the oleates.

The advantages which it is claimed the oleates possess over ordinary ointments are the following:

1. Their deep penetration.
2. Their freedom from rancidity.
3. Their cleanliness of application.
4. Their great economy.
5. Their antiseptic and deodorant properties.

A long list of substances have been included in the oleate preparations.

Among the number may be mentioned copper, mercury, bismuth, zinc, etc. These preparations seemed to gain their popularity by the success achieved by an ointment of the oleate of copper in the treatment of ringworm. The oleate of copper is an excellent application in ringworm. The oleate of mercury would be indicated in the inunction treatment of syphilis, and in the various parasitic diseases. The oleate of bismuth would be useful in rosacea, and zinc oleate in vesicular eczema, and excessive sweating or hyperidrosis. Dr. Shoemaker, of Philadelphia, reports favorably on the use of the oleate of copper in the removal of freckles or lentigo, yet he does not claim that it is a specific for this disfigurement. It will be remembered that Dr. Shoemaker is an enthusiastic advocate of the treatment of skin

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diseases by the oleates. Whether the oleate of copper will prove itself a better remedy in lentigo than a solution of corrosive sublimate remains for the future to decide. There is no question but that the oleates are a valuable addition to the therapeutics of skin diseases.

At the recent meeting of the Pennsylvania State Medical Society, held the last week in May, Dr. Shoemaker spoke of medicated soaps. Potash and soda soaps are medicated with tar, naphthol, carbolic acid, salicylic acid, sulphur, balsam of Peru, alum, camphor, eucalyptol, corrosive sublimate, etc. They must be used with caution, as they are productive of harm as well as good, and they should not be relied on exclusively.

Dr. Engelsted, of Copenhagen, Denmark, made a report some time ago in regard to the use of naphthol in skin diseases. This remedy was first proposed by Kaposi, of Vienna, as a remedy in scabies. Kaposi recommended an ointment composed of fifteen parts of naphthol, ten of chalk, fifty of green soap, and one-hundred of lard. The results reported by various dermatologists do not correspond, as might be supposed. Engelsted is not inclined to regard it with much favor, except, possibly in scabies, while Van Harlingen, of Philadelphia, is especially pleased with its action in scabies, and regards it as a valuable addition to the external treatment of psoriasis. In eczema, seborrhœa, and ringworm, he has not obtained the brilliant results claimed by Kaposi. In psoriasis it is used in the proportion of forty-five parts of naphthol, one-hundred of water, and two-hundred of alcohol. This solution is applied to the scaly portions of the disease morning and evening. It cannot be used many days at a time on account of the irritation it produces. Engelsted does not consider it as valuable as chrysarobin in the treatment of psoriasis. It is useful in a weak solution to allay itching.

Dr. Corlett, of Cleveland, O., recommends bromide of arsenic internally, and chrysarobin pigment externally in psoriasis.

Dr. George Henry Fox, in the second edition of his "Photographic Illustrations of Skin Diseases," speaks of a combination of chrysarobin, salicylic acid, ether, and collodion for the external treatment of psoriasis. The formula which he advises is as follows:

Chrysarobin	10 parts.
Salicylic acid	10 "
Ether	15 "
Flexible collodion	to 100 "

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This combination is known at the New York Skin and Cancer Hospital as the "Compound Chrysarobin Pigment." Dr. Fox speaks very highly of this treatment. Chrysophanic acid causes more staining of the integument, and sometimes excites a pretty severe dermatitis, besides injuring clothing. This combination of chrysarobin does not produce unpleasant effects.

Dr. H. G. Piffard, of New York, recently recommended bromide of arsenic in doses varying from one-hundreth to one-fiftieth of a grain, two or three times a day, in acne vulgaris.

Dr. Morrow presented a case of eczema of the leg at a meeting of the New York Dermatological Society, February 26th, 1884, treated with medicated gelatin plaster. The following formula was used:

Glycerin	250 parts.
Gelatin	1,000 "
Water	2,000 "

This was medicated with ten per cent. of oxide of zinc and one per cent. of carbolic acid. This was applied to the diseased skin, and allowed to remain a number of days. It forms a firm protective coating, and retains the medicinal application evenly in contact with the disease. Another way of preparing plasters is to spread a coating of the medicated gelatin or other combination on muslin. The muslin can then be cut in any desired shape, and made to fit any inequality of the surface.

Dr. W. T. Alexander, of New York, recently called attention to the success he had met with in treating ringworm of the scalp, in a public institution, by the use of a ten per-cent. solution of chrysarobin in liquor gutta-percha. This pigment was laid over the diseased ring with a brush, and allowed to remain a number of days.

Within the past year, a mode of preparing medicated powders for moist skin affections was brought to the notice of American dermatologists by Dr. Faithful, of Australia. The remedy is first dissolved in alcohol, ether, or chloroform. The solution is then mixed with starch or French chalk, and the alcohol, chloroform, or ether allowed to evaporate. The evaporation should be conducted without the aid of heat. A fine medicated starch or chalk-powder remains. Various remedies may be prepared in this way. Vesicular eczema, intertrigo, herpes, ulcers, etc., may be treated with these powders. "Anderson's Dusting powder," an old, but valuable remedy, is useful in the

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same conditions. This powder is composed of one-half ounce of zinc oxide, one drachm and a half of camphor, and one ounce of starch.

The somewhat remarkable statement has been made that a crop of warts has been removed from the hands by daily ten-grain doses of calcined magnesia, taken in the morning before breakfast. It has the merit of being harmless and simple, but I doubt very much the efficacy of the treatment.

Alder Smith recommends seven grains of chrysophanic acid to one ounce of chloroform in the treatment of ringworm.

Resorcin, a preparation from various gum resins, has been recommended in eczema, erysipelas, ulcers, wounds, and epithelioma. It is used in the proportion of one or two parts to ten of vaseline. It has not been used very extensively, and does not seem to have proven itself a very valuable addition to the therapeutics of the diseases mentioned.

Dr. R. W. Taylor, of New York, recommended a measure, last year, in the treatment of eczema marginatum, and of ringworm in general, of using a solution of corrosive sublimate in tincture of myrrh, or compound tincture of benzoin. Two to four grains to the ounce is the strength used. It is perhaps as well to commence with the weaker solution. The principle of using the benzoin or any of the gum resins is to furnish a vehicle for retaining the corrosive sublimate in contact with the diseased patch of skin. It is not thought that the tinctures have any therapeutic effect on the disease.

Dr. S. Sherwell, of Brooklyn, read a paper before the annual meeting of the American Dermatological Association, in August, 1884, on the treatment of acne rosacea in the male subject. He made the basis of his remarks some old chronic cases of acne rosacea. They had resisted every plan of treatment. They were finally relieved of the disease and its annoying disfigurement by the introduction of the cold steel sound. The sound was passed every third day for a time, gradually increasing the interval to once a week, as improvement followed.

At a meeting of the New York Dermatological Society, held March 24th, 1885, Dr. George Henry Fox made some remarks concerning the balsam of Peru, combined with the various metallic oxides, as an adhesive dressing in skin diseases. Zinc, bismuth, magnesia, etc., may be thus combined. He also spoke of the treatment of psoriasis

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by salicylic acid in castor oil. Two to five per cent. is the strength ordinarily used.

In the April number of the *Journal of Cutaneous and Venereal Diseases* for this year, is a note from Dr. Greene, of Christiana, recommending iodide of potassium in fifteen-grain doses three or four times a day, gradually increasing it, for psoriasis.

Pyrogallic and salicylic acids have been recommended in the treatment of chancres and venereal ulcers. Of the two, the pyrogallic has the greater weight of evidence in its favor, as being more prompt and certain in its action. It should not be combined with soap or other alkali, as it is thus readily decomposed.

Calx sulphurata, an article brought into prominence about fourteen years ago by Dr. Sydney Ringer, as a remedy in furuncles, is of value in other skin affections. Cane reported favorable results from its use in 1878, in acne, and in eczema rubrum.

One of the latest remedies for psoriasis is the fluid extract of burdock seed. It is recommended in the dose of twenty drops to one drachm three times a day. I have used it with apparent benefit, but I have not had an opportunity of testing it sufficiently to be able to report intelligently in regard to it. It has been spoken of favorably by a number of physicians, yet it does not seem to have gained the confidence of those who know the most of dermatology.

Dr. E. L. Keyes, of New York, read a paper before the New York Dermatological Society, the first of this year, entitled "Note on Hydrochlorate of Cocaine—Its Possible Dermatological Uses." Briefly, it is recommended in cutting out small tumors, opening abscesses, in epilation, applying caustic to syphilitic sores, etc. There is no no doubt but that it can be used to good advantage in many skin affections.

I wish to say a few words in regard to phytolacca decandra. It is well known that this remedy possesses the remarkable power of arresting glandular inflammation, especially of the mammæ. The thought has occurred to me, of late, that it might prove advantageous in acne, and possibly in comedo and seborrhœa. I have not had occasion to try it as yet, but intend to give it a trial at the first opportunity. It may not be of any value, but a thorough test of it would do no harm.

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Surgery.

Edited by G. FRANK LYDSTON, M.D., 125 State St.

The Expectant Treatment of Fracture of the Neck of the Femur.—Dr. Hal C. Wyman, Surgeon to the West-end Dispensary, Detroit, calls attention in the *Med. Record*, of the 9th inst., to what he considers a great abuse of the surgeon's privilege, in the treatment of fractures and injuries of the neck of the femur, especially in old persons. He regards the manipulation resorted to in such cases to determine the presence or absence of crepitus, as cruel and fraught with injury. It is the usual practice in the case of injuries in the region of the hip, to flex the thigh on the abdomen, to rotate the limb and to do all other conceivable things in the effort to diagnose the precise nature of the difficulty. If crepitus is discovered, the patient has fracture of the neck, but on this distinctive symptom's failure to show up, he has intracapsular fracture, if the other diagnostic signs can be discovered. Dr. Wyman asks what good can come to the patient from the determination of a distinction of that kind? "You may say," he continues, "that it makes a great difference in the treatment. So far as treatment based on that distinction is concerned, diagnosis is immaterial. You do best with these cases of suspected fracture when you use no restraining apparatus. Is it strange that the old lady (in the case reported) should turn out to have an ununited fracture or absorption of the head of the femur, after the manipulation her injury was subjected to, then with weeks of confinement in apparatus to restrain the movements of the joint, to have the bed sores, and broken general health? No harm can come to a patient from an examination which consists in a careful interpretation of the impaired mobility and abnormal position of the limb, the length, flexion, extension, abduction, adduction, inversion, eversion, relatively of the injured member to its sound fellow. But beyond this the respecter of good surgery will not go. Take almost any case of ununited fracture of the femoral neck, and injury will show that the patient submitted to a deal of manipulation for purposes of diagnosis and adjustment of apparatus, at or about the time the injury was received. Any case of injury to the same part which has resulted in good union and useful limb, was treated on the let-alone principle, i. e., making the patient as comfortable as possible with the limb in the

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position where the automatic action of the muscles of the thigh and hip places it. My own experience embraces not a few of these injuries, and I can say that I have found cases of suspected and known fracture of the femoral neck to do best when the patient was kept in the sitting posture, the tuberosities of the ischia resting on a hard seat, the feet side by side, and the legs bound loosely together. A hard seat is essential, for a soft cushion permits the tuberosities to sink so that the weight of the trunk and upper extremeties is carried on the soft parts of the gluteal region, comprising the sciatic nerves and giving rise to severe pain. Non-union is not a common result of fracture of the surgical or anatomical neck of the femur, no matter what age the patient may be, when this plan of treatment is followed." —*Med. Age.*

A Severe and Unusual Circular-Saw Accident.—On the 12th day of last November, I was called in haste to attend B. T—, aged forty-five, who met with an accident in a saw mill. On arrival I found him lying in bed very much exhausted, and on making examination found the following conditions and received the history of the circumstances relating to the case: It appears that he was taking heavy planks away from the saw (a large circular) as fast as cut, he lifting one end and another man the other. By some mischance he backed up against the saw, which at the time was not running at full speed; being behind the saw, he was struck in an upward direction. Leaving out a description of eleven severe wounds on the posterior part of the thigh, as, compared with the main injury, they seemed of small importance, the examination showed a deep, ragged cut, commencing about an inch below the anus and extending upwards about fourteen inches in nearly a direct line. The anus, about four inches of the rectum, and the entire coccyx were torn out; the sacrum at the lower portion nearly cut through and the remainder of the wound a torn and ragged mass of muscle and integument.

As it was evening and quite dark, I made him as comfortable as possible and directed that, early in the morning, Dr. W. M. Tuller, of Bowling Green, should be sent for to assist me in doing whatever, on more careful examination, should be found necessary. As soon as it was light enough the next morning, we proceeded to dress the wound, the patient refusing to take chloroform. After paring off several rough edges and carefully cleansing, the rectum was seized with a tenaculum and brought out. The anus having been entirely

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destroyed, it was found necessary to make a new one, which was done by stitching the two edges of integument, using eight silk sutures for this purpose, also taking precautions against contraction. The present orifice is about three and one-half inches higher than the natural anus. Twenty-eight sutures, besides adhesive strips, were required in all. A full dose of opium was then given and the patient put to bed. The after-treatment for the next eight days, consisted in merely cleansing the wound and giving opium to confine the bowels. The inflammatory reaction was very slight.

November 22d, the patient complained of uneasiness, and was somewhat alarmed about not having a passage. On examining the new anus I found the entire edge of the gut had united, hardened fæces nearly protruding. The fæcal mass was removed by means of a scoop improvised for the purpose. Next morning gave half an ounce of Rochelle salts, to be repeated in the afternoon if necessary. Copious evacuation followed and patient felt much relieved. From this time on only a few minor matters connected with the bowel and wound were attended to, the patient making a good and unexpected recovery. I saw him last about a month ago. He had rode to town on horseback, had been doing some work and was feeling well. The absence of a sphincter is, of course, the great drawback. This is the first man I ever heard of who sat on circular saw, in motion, and lived to tell the tale.— *W. E. Hughes in Med. Age.*

Electrolysis in Stricture of the Urethra.—We have frequently had occasion to refer to the use of electrolysis in the treatment of stricture of the urethra. In the hands of some it has seemed to prove very beneficial, and converts to its merits are being constantly made. Dr. Robert Newman publishes a paper on this subject in the *Journal American Medical Association*, April 25, 1885, in which, after reporting one hundred cases, he says that these and many other reports of cases speak for themselves, so that at the present time 1,000 could easily be collected, and that the most fastidious medical skeptic ought to be convinced by this report of one hundred cases cured without any relapse during three to eleven years' careful observation. By such unique good results the methods of electrolysis in the treatment of stricture of the urethra is fully tried and established, and every day brings new converts and makes new friends.

He thus formulates the details of treatment:

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1. Begin the use of electrolysis carefully; do not cauterize, only absorb; in many cases the current of six cells will suffice.

2. Regulate the power and current of electricity according to the susceptibility of the patient.

3. Repeat seances in intervals not too frequent in succession.

4. Do not grease the bougie with substances that are non-conductors, and would insulate.

5. Wet your electrode sponges with hot water; keep the plates in the battery fluid only during the operation.

6. Never use force with your bougie; never cause hemorrhage.

7. Do not operate while the urethra is in an acute or even sub-acute inflammatory condition, or when it is too painful.

8. Use your battery fluid weak.

9. Never use two bougies in succession with electrolysis during one seance.

10. Practice at first only one method by absorption. "*Weak currents; long intervals.*"—*Med. and Surg. Rep.*

Eye and Ear.

Edited by J. E. HARPER, M.D., 163 State St.

Traumatic Dislocation of Right Auricle.—*W. F., aged 14, was thrown from a frightened horse, falling heavily on his right side upon the ground. He was slightly stunned and somewhat bruised, but otherwise uninjured save the right auricle, which was nearly torn from his head, hanging only by a small piece of integument of the cheek. He was taken to the nearest doctor, who happened to be a homeopath, and who placed the auricle in such a position as to cover the external meatus, the concha coming directly over the meatus. The parts healed rapidly, but the boy was deaf in this ear.

In the course of a few weeks, after the boy returned to school (the doctor having discharged him as cured), he experienced some pain, followed by swelling, and a post-auricular abscess formed, which was opened by the doctor. I am satisfied it was not a mastoid abscess. What prevented the pent-up secretions from finding their way into the mastoid cells, and forming an abscess there, I am unable to say, for pus escaped through the eustachian tube into the mouth.

*By Arnold P. Gilmore, M.D., Attending Surgeon to the Illinois Charitable Eye and Ear Dispensary, Attending Surgeon to the North Side Eye and Ear Infirmary.

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In this condition, with a fistulous opening behind his ear, which the doctor luckily was unable to close, the boy was sent to a brother specialist, but owing to the death of the latter gentleman shortly afterward, treatment ceased, the difficulty being in no way alleviated. The boy then consulted two eminent surgeons and one prominent ear surgeon; all advised that the auricle be dissected loose and replaced in its proper position, but to this the parents objected, and the matter was dropped.

Four years after this the boy consulted me, nothing having been done in the meantime. The scar around the auricle was plainly visible, extending from a little in front of the extreme upper attachment of the auricle around behind and over two inches onto the cheek. Unless your attention was specially directed to it you would not notice that one auricle was a little higher and situated a little farther front than the other. He could only hear the watch in contact with the right ear; with the left ear he could hear it at four feet. Behind the right auricle was a fistulous opening in the lower portion of the scar, from which escaped the foulest pus it has ever been my misfortune to smell, and he claimed he was in consequence of this odor excluded from social intercourse—a statement I did not doubt. He wanted this discharge cured; it had been discharging four years constantly. He was not so particular about having his hearing restored, but he wished no longer to be an outcast from society.

I decided to attempt first the formation of an artificial opening through the coucha by dilatation, rather than to dissect loose the auricle. In a cicatricial band running horizontally across the coucha, I found a small depression into which I passed a Bowman No. 1 sound, finding only slight resistance, I forced the probe through into the meatus; the withdrawal of the probe was followed by an escape of this muddy-looking, rather thin, fetid discharge. I then introduced larger probes one after the other until I made an opening large enough to thoroughly cleanse the meatus with a disinfectant wash. I then insufflated boracic acid, and finally introduced a small sponge tent. The next day the sponge was distended and the opening was a trifle larger. This treatment was repeated daily, using each time a larger probe. These probes I improvised from pen-holders, lead-pencils, etc., after the opening was too large for lachrymal probes. There never occurred any severe inflammation. The momentary pain of the operation was considerable, but subsided quickly; the bleeding was

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inconsiderable, and gave no trouble. At the end of the second week the discharge had greatly diminished and was only faintly offensive, the character having changed to laudable pus. When the opening was large enough to introduce an ear-speculum, I discovered, as I expected, that the drum and oscicles were gone, and that the mucus membrane was granular. At the end of the fourth week I had a silver ferule made, about 5-8 of an inch long and the size of a French 22 urethral sound, with little shoulders on either end to prevent its slipping either in or out after it was forced into position. This worked beautifully, and permitted the patient to clean his own ear, necessitating fewer visits to my office.

I noticed that if this tube was left out a day or two the artificial meatus would contract so as to make its introduction very difficult. At the end of the seventh week the discharge ceased and the hearing was much improved. He could hear the watch at eight inches. I now had another tube made somewhat larger in caliber and an improvement on the old one.

I left the patient at this time for a two months' vacation. On my return I found he had worn the tube without inconvenience and that it was loose and easily removed. The tendency to contract previously noticed had apparently ceased. The hearing was now much improved. He could hear the watch at two feet. He claimed to hear as well with one ear as with the other. To my surprise an entirely new drum membrane had formed. I know the reproductive power of this membrane is very great, but I had not expected such a result in this case. With the pneumatic otoscope the to-and-fro movements of this membrane were plainly visible. I punctured the membrane and found it to be soft and much less resistant than the normal drum membrane, but it served the purpose of protection to the middle ear.

This case is unique. In the literature at my command I am unable to find a similar case reported. In Wild's Aural Surgery, published in 1853, I find more references to injuries of the auricles than in more recent authors. He refers to the French soldiers, after the battle of Constantine, as suffering especially from wounds of the auricle, but he reports no case where the auricle has been torn loose and replaced, i. e. misplaced, with the subsequent consequences. He also speaks of the German students suffering from injuries to the auricle from their sword duels, and during the faction fights in Ireland says: "I have dressed many dozen auricles split and bruised by the blackthorn

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sticks," but he gives no report of any special case. Neither Toynbee Roosa, Burnett nor Buck report a similar case to mine. Dr. Buck says: "Out of a total or nearly 2,800 cases of ear diseases in the N. Y. Eye and Ear Infirmary (1878) there was but one case of lacerated wound of the auricle—from which I infer that traumatic disease of this part of the body is rare." I should be glad to communicate with any one who has had a similar case.

At this date, 1½ years after treatment ceased, the hearing remains as good as ever, and the opening has contracted only slightly.

70 Monroe street.

Books.

THE STUDENT'S MANUAL OF HISTOLOGY. For the use of Students, Practitioners and Microscopists. Third Edition; Entirely Rewritten, Greatly Enlarged, and Newly Illustrated. By Charles H. Stowell, M.D., F.R.M.L., Prof. of Histology, and in Charge of the Histological Laboratory of the University of Michigan.

The author of this valuable work, in a clear and concise style, points out all that there is of the most essential in the study of microscopy, both in the field of investigation and in the mode of handling the instrument. The busy practitioner as well as the student, will derive much benefit from the perusal of this book. C. C. P. S.

MODERN THERAPEUTICS OF THE DISEASES OF CHILDREN, WITH OBSERVATIONS ON THE HYGIENE OF INFANCY. By Joseph F. Edwards, M.D.

This is an excellent compilation of the most renowned authors in pediatrics, both domestic and foreign, whose perusal affords much available information with a small expenditure of time. This work commends itself to the profession. C. C. P. S.

A TREATISE ON MEDICAL EXAMINATION FOR LIFE INSURANCE. By J. R. Levan, M.D., Medical Director of the Fidelity Mutual Life Association of Philadelphia. 1885. Price, $2.00.

Under the above title is a work just issued, which treats of the various diseases liable to be encountered by the examiner for life insurance, with especial reference to the remote effects of the same and their influence upon the longevity of the individual.

The author, who has for some time acted as medical director for one of the most careful life insurance companies now doing business,

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and who has for years made the subject a matter of special study is well qualified to do justice to a work of this kind, a fact which is abundantly demonstrated by the complete, simple and systematic arrangement adopted, which thereby renders the work particularly admirable and useful. It contains nearly 200 pages, and taken all in all we consider it the most complete thing of the kind we have yet seen, and a work which will prove to be interesting and instructive to every medical man, and one which should especially be in the hands of every medical examiner for life insurance. H. J. R.

MODERN MEDICAL THERAPEUTICS, A COMPENDIUM OF RECENT FORMULA AND SPECIFIC THERAPEUTICAL DIRECTIONS. From the Practice of Eminent Contemporary Physicians, American and Foreign. By George H. Napheys A.M., M.D., Edited By Joseph S. Edwards, M.D., and D. G. Brinton, M.D. Eighth Edition; Enlarged and Revised.

We have looked into the above work and deem it an excellent compilation of formulæ and therapeutical precepts, abstracted from the best authorities and representing the choice practice of the day. The mode in which the subjects are presented and the neatness of the folio book which contains them, concur in creating for it a reserved place in every progressive practitioner's library. C. C. P. S.

POISONS, THEIR EFFECTS AND DETECTION. A. Wynter Blythe, M.R.C.S., F.C.S., etc. Vol. I, June, Vol. II, July, 1885. Wm. Wood & Co., New York.

One can scarcely do justice to a subject so interesting and extensive as this in a few short remarks, besides the name of so eminent an authority as A. W. Blythe vouchsafes the character and quality of the work. There are some original features however, that deserve especial mention.

Dr. Blythe first treats of the history of poisons and poisoning under the heading of "Old Poison Lore." This is of interest and use, both to the chemist and physician, inasmuch as the advance of civilization in this branch, if it may be so termed, is most finely detailed. Dr. Blythe has here shown how, with the advance of knowledge, the born poisoner has used both art and artifice to conceal his fiendish act and baffle the skill of the physician and toxicologist; but thanks to modern science, the villainy of the worst enemy of man can easily be detected, if that villainy develops itself in the administration of some poison.

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We find Dr. Blythe is ever abreast of the times, and in this most excellent work he has given us the long list of common and rare poisons, well classified according to ideas of his own. The characteristics, effects and antidotes are well classified, being brought up to the best works of the times. Original investigation seems to have been a good share of Dr. Blythe's work, especially on the poison of some venomous reptiles, fish, etc.

The classifications are admirable and well adapted to the use of the toxicologist.

More space is devoted to that growing and ever-interesting subject —anclinic, alkaloids, ptomaines, septicemia, patriæ or changed food— than is given in any English work it has been our pleasure to peruse.

In the appendix Dr. Blythe has introduced some most interesting and valuable work on blood stains, which of itself is a subject of growing interest and importance.

Perhaps the best feature of all for the physician, is the article on "Treatment by Antidotes or otherwise, of Cases of Poisoning." Here the doctor has given all the latest and best antidotes in cases of suspected or known cases of poisoning, the apparatus to be used, and the mode of procedure. This alone will sufficiently recommend the work to the physician.

This work is evidently not intended as a work on medical jurisprudence or forensic medicine, but it gives nevertheless, a fund of information eminently adapted to the toxicologist or physician.

C. B. G.

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Miscellaneous.

SEND for samples of Fellows' Hypophosphites and mention WESTERN MEDICAL REPORTER.

SEE Anglo-Swiss Milk advertisement on advertisement page. Send for samples and mention WESTERN MEDICAL REPORTER.

SEND $1.25 to John Barry, 62 Fulton St., New York, and he will send one of his reliable thermometers, post-paid.

SEND to Dr. Carl Jensen, 2039 Green St., Philadelphia, Pa., *for samples* of his celebrated Crystal Pepsin, and mention WESTERN MEDICAL REPORTER.

YOUR attention is specially called to the ad. of The Duffy Malt Whiskey Co. They will send a quart bottle, as a sample, for $1.25, in a neatly packed wooden case, without mark, if WESTERN MEDICAL REPORTER is mentioned. See ad.

SEND to the reliable and old established house of Wm. R. Warner & Co., 1228 Market street, Philadelphia, Pa., for *samples* of *soluble* pills and granules, and mention WESTERN MEDICAL REPORTER.

I HAVE tested PEACOCK'S BROMIDES *without a single failure.* It acts like a charm, without any bad after effects. A. W. K. NEWTON, M. D.
528 Tremont St., Boston, Mass.

W. R. WARNER & CO. have received the first premium at the World's Exposition, New Orleans, for great uniformity and solubility for their Sugar-coated Pills. This is the 9th World's Fair Prize which attests to their excellence.

I TRIED "Peacock's Fucus Marina," in two cases of typho-malarial fever (or remittent bilious fever with typhoid complications) *with success*, and I also used it in one case of jaundice with the best results. P. MCADAMS, M.D.
Rosedale, Ohio.

AT A meeting of the Union District Medical Society (counties in Ohio and Indiana) held at Oxford, Ohio, October 25, 1883, the Society adopted and ordered published the following: "Resolved, that after carefully inspecting the facilities of the Oxford Retreat, and from a knowledge of the eminent abilities of its Superintendent, we hereby endorse it as an institution in every way adapted to the care and treatment of the cases for which it was designed, and commend it to professional support."

National Pharmacy Association, Baltimore:

DEAR SIRS—I have used mineral earth in a case of ulcerated leg of twenty years standing; other remedies were tried unsuccessfully. Since the application of the Mineral Earth the sores are almost entirely healed; granulation set up immediately with the first application, pains ceased, and at this time, viz: four weeks after its use, cicatrization is almost complete, and I am entirely satisfied with its antiseptic properties. J. R. MCCULLOUGH, M.D.
No. 9 Halsted Street, Chicago.

HYDROLEINE.—To those already familiar with the preparation, it needs no explanation; to the thousands who have become disgusted with the use of Cod Liver Oil, and its effects on the stomach, when administered, undiluted or in some of the abominable pretexts of mixture so commonly in vogue in former years, a word of explanation will not be out of place, nor unwelcome after once familiarized with its use. Hydroleine as signified by its name, is not only a mere mixture, but is a real dilution, reducing the acridity perhaps by means of its trituration in water, prepared to hold its finer globules in attenuation. It is the only pancreatized Cod Liver Oil preparation in the market. Delicate stomachs will readily retain it when Cod Liver Oil and the so-called emulsions are rejected. You have only to try it to be convinced.

SINCE the introduction of "Ringer's English Bin-Oxide" no progressive physician resorts to the old woman's remedies hitherto in use. Price $1.00. Clarke & Co., Importers, 819 Arch st., Philadelphia, Pa.

I HAVE used LISTERINE for about five months; first upon myself in fermentative dyspepsia, and was delighted with its effects; since which I have employed it on cancerous and fetid ulcers, and upon the surfaces about the neck that have been denuded when removing the thyroid gland, and other tumors from that region. It is also su-

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perior to anything I know of for washing off foul-smelling stuff from the hands after dissections. With an atomizer, a solution thrown into the air-passages quickly relieves suppuration and fetor. WM. A. BYRD, M.D.
Quincy, Ill.

METHO-GLYCEROLE OF BISMUTH AND HYDRASTIA.—This remarkable alterative and sedative to mucous surfaces has been in use by the profession for ten years, being first prepared by Chapman, Green & Co., in 1872. They will mail to the profession a descriptive list of their specialties, also a sample of the above if express charges are paid and WESTERN MEDICAL REPORTER mentioned.

NORWICH, CONN., MAY 21st, 1885.

Mr. Jno. W. Goodwyn:

MY DEAR SIR:—Allow me to thank you for generous sample of your compound syrup of hypophosphites which, I received in due time. I am so pleased with its action, particularly in certain forms of hereditary syphilis, that I have requested my druggists to provide themselves with a supply of it. Very truly yours,
CHAS. M. CARLETON, M.D.

BATTLE & Co.—I take great pleasure in saying, after using Papine in a test case of hypochondriasis, *marked good effects* were produced to the great satisfaction of my patient and her attending physician. W. A. HUNT, A.M.,M.D., Lynnville, Ind.

I AM much pleased to state that I am now using CELERINA in a hopeless case of cancer (general systemic) with very gratifying effects to the patient. She insists that it has almost obviated the necessity for morphia. T. N. CLARK, M.D.
Reagan, Falls Co., Texas.

PROLAPSUS UTERI.—I prescribed ALETRIS CORDIAL (Rio Chemical Co.) for a patient who had prolapsus uteri, in what Thomas calls the first degree, due to the loss of tone in uterine ligaments and enfeeblement of other uterine supports; the Aletris Cordial, together with hygienic measures, effected a cure. D. W. BARRON, M.D.
Unionville, Ind.

GONORRHŒA, GLEET AND LEUCORRHŒA.—I have tried Kennedy's Pinus Canadensis and am glad to say *that it is the best astringent* I have ever used. The *White* is an *especially* fine injection in leucorrhœa, gonorrhœa and gleet. W. E. IRBY, M.D.
Crawfordsville, Ark.

NERVOUS PROSTRATION AND BRAIN TROUBLES.—For some time past I have used CELERINA in my practice. I used it first in a case of *nervous prostration and found it a success when other remedies failed.* Would recommend it in all nervous diseases or brain troubles. I find it soothing, lasting and permanent in its effects, and in many cases of nervous debility and loss of *will power in certain directions*, produced by indiscretions, etc., I consider it an invaluable remedy. L. ANDREWS, M.D.
South Richland, N. Y.

ANGLO-SWISS MILK FOOD.—No more striking evidence of the growth of the business in condensed milk can be given than in the statement of the Anglo-Swiss Condensed Milk company, that "the annual production of condensed milk is estimated at 60,000,000 cans, manufactured by eleven different firms in Europe and America, of which the above named company manufacture 40,000,000; that is to say, the Anglo-Swiss Condensed Milk company supply two-thirds of the world's entire demand, and the other ten firms the remaining third." This great house has its parent establishment in Cham, Switzerland, with branches in England and America, and it is claimed that this immense growth is due entirely to the superior and uniform purity of their productions, coupled with the low prices at which they are sold.

THE HYDRANGEA ARBORESCENS.—The value of this native plant in renal affections was first made known to the medical public by the former editor of this journal, Dr. S. W. Butler. Recently Lambert & Co., of St. Louis, have combined the active elements of the plant with lithia in a preparation called "Lithiated Hydrangea," which unites the virtues of both these remedies. In the *Chicago Weekly Review*, two cases of rheumatic gout with renal complications are reported by Dr. F. S. Senier, of Waukesha, Wis., where this preparation in doses of a drachm, thrice daily, largely diluted, acted with prompt and satisfactory effect. The combination seems to us a happy one.—*Med. and Surg. Reporter*, Philadelphia.

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THE WESTERN
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Medicine.

Edited by WM. E. QUINE, M.D., 3151 Wabash Ave.

Pleuritic Effusion.—No apology is ever needed for taking up in a clinical lecture the subject of pleuritic effusion. Whether we regard its frequency, or the many interesting points presented in connection with the question of diagnosis, or the all-important matter of treatment, we have brought before us a subject, which in its many-sided bearings has few equals in the whole range of practical medicine. As it happens, I have had under my care recently, several cases of pleural effusion, some of them resembling and some differing from each other; and I propose now to bring these before you so as to compare and contrast them, believing that they will be found to present points which you may profitably study in view of the fact that you are almost certain to meet with similar cases in your future practice.

CASE 1. *Large pleurul effusion (left) of considerable standing; paracentesis, four pints and sixteen ounces of fluid removed; recovery, with shrinking of the affected side.*—The subject of the above title was a police constable, aged twenty-six. His family history was excellent. His father and mother had both died, but of diseases of the nervous system, at the ages of sixty-six and fifty-four respectively. He had two brothers and five sisters alive and healthy, none having, so far as he knew, suffered from any kind of lung disease. He had himself always been a temperate liver. Four months before coming

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under my care in the hospital he had had an attack of pleurisy, followed by cough and shortness of breath, for which he sought admission, as his condition had been gradually becoming worse. On admission (Nov. 8th), he was described as a robust, tall, healthy looking man, complaining of pain in the left side and of a dry cough. The pain was felt all over the left side, being, perhaps, more correctly described as a sense of weight and uneasiness, and was aggravated when he turned over on the right side in bed. His temperature was 102.4°; pulse 120; respiration 21. Tongue moist and slightly coated. On examining the chest the left side was found to be universally dull on percussion, both back and front, with the exception of an area of triangular shape near the junction of the sternum and clavicle, where there was a certain amount of resonance. Below this the dulness extended across the middle line and encroached upon the right side of the chest to the extent of two inches. Movement in the affected side was much diminished and vocal vibration was abolished over the dull area. Faint bronchial breath sounds were heard towards the apex, being most marked in front. Elsewhere there was absolute silence on respiration. The right lung presented good resonance, and, except where encroached upon in front by the dulness coming from the left side, the breath sounds were loud and harsh; no adventitious sounds were heard. The heart's impulse was impalpable and invisible except in the epigastrium, where there was slight pulsation. The first sound was most distinctly heard over the ensiform cartilage; both sounds were normal. As regards the abdomen, the liver dulness extended about one inch and a half below the costal margin in the nipple line, and the lower border of the spleen could be felt on deep pressure. The urine was normal.

On the day after admission paracentesis was performed, the trocar being introduced in the sixth left interspace in the mid-axillary line, the patient lying on his back. Four pints and sixteen ounces of clear greenish-colored fluid of a specific gravity of 1020, rich in albumen and of neutral reaction, were removed. His breathing became distressed towards the end of the tapping, and he was seized with a severe paroxysm of coughing, when the operation was concluded and the cannula withdrawn. On percussion now in the recumbent position the resonance over the left front was found to be good as far down as the nipple; the dulness to right of the sternum had disappeared, and harsh breath sounds were audible over the previously

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dull area. The vocal fremitus was also restored, and the heart's apex, judging by the distinctness of the first sound, had apparently come over about an inch towards the left. Posteriorly the resonance was fair down to the middle of the scapula, a corresponding change having also taken place in the other physical signs. In the evening the temperature was 103.6°; pulse 104; respiration 30. He had had no pain, but the cough had been rather troublesome, and was accompanied with frothy mucoid expectoration. Numerous mucous rales were heard over the upper part of the left front. Next day his breathing became more comfortable, but the evening temperature still remained high (103.8°), that of the morning having been only 100.4°. A conspicuous increase in the amount of urine excreted was noted for a few days after the tapping, forty-eight, sixty-four, and seventy-seven ounces being measured on three consecutive days.

About a week later (Nov. 16th), the following note was made: "Resonance is rather less than normal over the upper half of the left back; completely impaired from the middle of the scapula downwards. In front there are fair resonance and breath sounds down to the nipple line. At the posterior apex the breath sounds are of a tubular character. The heart's apex is still indistinguishable, but the sounds are loudest a little to the left of the ensiform cartilage. Fremitus is well marked over the left front, and also over the upper half of the left back. Whispered voice sounds are well heard over the dull area."

Further progress was marked by the note made after the lapse of another week, which stated that resonance was good in front to below the nipple; behind not so good, but not quite dull, except for about three inches at the extreme base; breath sounds being faintly heard down to this level.

About a fortnight later (December 10th), marked flattening was noted at the left anterior apex; the resonance was fair, however, the breathing being bronchial and the expiration prolonged. Posteriorly the resonance was impaired below the mid-scapular region. The breath sounds were distinctly audible as far down as the inferior angle of the scapula. The first heart's sound was most distinct in the fifth inter-space one inch and a half internal to the nipple line. There was some drooping of the left shoulder; no cough or pain. He was discharged a few days later in this condition. Regarding temperature, I may say that it remained febrile, even in the morning, for

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about ten days after the tapping, and scarcely reached the normal at night during the whole period of his stay in the hospital. With this he had occasional sweating at night, but did not lose weight.

The foregoing case exhibits conspicuously all the most important diagnostic signs of pleural effusion—to wit, dulness on percussion, abolition of tactile fremitus, and displacement of organs. There being no room for nice refinements in diagnosis, its chief interest and usefulness lie in the matter of treatment. You will remember that a quantity of the fluid in the man's pleura was removed by paracentesis the day after his admission into the hospital, the first time I saw him. My reason for proceeding at once to operative interference was that from the history it was apparent that the lung had been compressed for a considerable time, and every additional day of compression diminished to some extent the prospect of a full re-expansion of the lung. How completely such fears were justified, even although relief was given at once, appears from the fact to which I have called attention that the upper part of the affected side in front presented ultimately marked flattening, and that the shoulder drooped from shrinking of the side. I should add that the base of the affected side was blistered some days after the tapping; and this, I think, is good practice generally. There are objections to blistering in the first instance, in presence of a large effusion, to which I shall refer later on.

Case 2. *Recent pleural effusion (right); paracentesis; recovery.*—Second case does not differ greatly, except in one important particular, from the one I have just narrated. The patient was a man, thirty-six years of age, a porter by occupation, and rather given to alcoholic indulgence. He stated that his health had always been good up to his present illness, which began about a fortnight before he came under observation, with pain in the front of his chest on the right side, accompanied by cough and difficulty of breathing. The cough was most troublesome when he lay on his left side. On admission (Nov. 12th), his pulse was 96; temperature 101°; respiration 28. Tongue coated and tremulous. He was described as a well-nourished man of short stature, of an alcoholic appearance, complaining of shortness of breath and cough. On examining his chest the whole of the right front was found to be dull on percussion, the dulness passing across towards the left side to the extent of one inch and a half opposite the mid-sternal region. Breath sounds were heard over the dull area, faint and of a tubular character, except at the apex,

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where they were well marked. The expiratory murmur was prolonged. Vocal vibration was scarcely perceptible. The right back was also dull, vocal vibration being abolished except about the interscapular region. Breath sounds were heard, distant and of a tubular quality, with nasal voice sound. Resonance was good over the opposite lung, both in front and behind, the breath sounds being harsh and accompanied by some rhonchus. The heart's maximum impulse was seen and felt in the sixth interspace just outside the nipple line, the sounds being normal. The upper border of liver dulness could not be delimited, but the lower border came nearly two inches below the costal margin in the nipple line. The urine was normal. Whispered voice sounds were well heard over the dull side, both back and front. Expectoration was abundant, mucoid and frothy.

No change having taken place in the physical signs under medicinal treatment during a week's stay in the hospital, he was tapped (Nov. 9th), in the sixth interspace in the mid-axillary line, and three pints five ounces of greenish-colored serous fluid evacuated, having a specific gravity of 1025, of neutral reaction and solidifying on boiling. After the operation fair resonance on percussion was found over the whole of the right front and down to the level of the puncture as the patient lay on his back. Breath sounds also were well heard, and there were no adventitious sounds and no troublesome cough. When sitting up the back was nowhere absolutely dull, although the resonance was considerably impaired, and feeble breath sounds were everywhere audible with a few friction-like creaks towards the base, on deep inspiration. The evening temperature was 102.2°. In three days he was allowed to get up. On the fourth day after the tapping (Nov. 23rd), the breath sounds in the front were accompanied by a few creaking sounds on deep inspiration; the area of liver dulness was not found to come below the costal margin, and the heart's first sound was heard most distinctly in the nipple line, the impulse being impalpable. His appetite was improved and his tongue clean. Temperature was still moderately febrile, averaging about 100°. The creaking sounds over the right front noted above developed in two or three days (Nov. 26th), into coarse leathery friction, unaccompanied by pain. A blister was applied to the right back about this time. His temperature now went down to about normal, sometimes a degree more, sometimes a degree less, and his progress in convalescence was uninterrupted, although not very rapid.

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A note made after the lapse of a fortnight (Dec. 10th), is as follows: "Temperature 98°; pulse 104. No friction is heard now over the right front. The resonance is fair down to within an inch of the nipple, and much impaired below that level. Over the right back it is impaired everywhere, but most markedly so at the base. Breath sounds are audible all over the back, faint, and of rather a tubular character. A few sonoro-sibilant sounds are also heard here. The first heart's sound is most clearly heard in the nipple line. The breathing over the right front is very feeble." A few days later he was discharged.

At first sight this case seems like a counterpart of the other, with the exception that here the right side was involved. But in view of treatment there was this point of difference, that whereas, in Case 1 the fluid had for a long time remained in the pleura, exerting compression on the lung, and bringing about a state of matters out of which complete re-expansion of the lung could hardly be looked for, and, in fact, did not take place, in Case 2 the trouble had only existed for a fortnight, and I thought it well to make trial of rest, nursing, and medicinal remedies before proceeding to paracentesis. As regards blistering, I have no great faith in its efficacy in the presence of a large effusion, except as an adjunct to paracentesis. At the least, it seems to me to involve a waste of time. To warrant you in expecting any result from it, it must be carried out severely and persistently; and done in this way it involves to the patient a serious amount of irritation and positive pain, not to say loss of sleep. Another objection to it before paracentesis is that it renders the skin very tender and may greatly increase the discomfort of paracentesis, when the latter becomes inevitable.

There are three conditions which I would say call for tapping, but with varying degrees of urgency, and the objects with which we resort in each case to operative measures may be thus stated:—(1) To avert death; (2) to avert danger, and (3) to expedite a cure.

With regard to the first of these, if you find a patient in whom a rapid effusion has taken place, with quick breathing and distressing dyspnœa—one pleura nearly full, perhaps, and the heart displaced—tap him at once. Every hour's delay is fraught with imminent danger. Even if paracentesis were obnoxious to the dangers which some see in it, there would be no room for hesitation here. But in the second case we may suppose that the effusion, although as great in amount,

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has taken place slowly, and there may only be discomfort in breathing on exertion. Here again, if the effusion be extreme in amount, and especially if the case be one of left-sided pleurisy, I would still say remove some of the fluid. The dangers are not to be compared with those of the previous supposed case, but they are not absent altogether, for something may go wrong with the other lung, or the heart may be so much displaced as to induce thrombosis from nipping of some of the large vessels, and fatal syncope. In the third case, where the effusion, although perhaps only half filling the pleura, persists for some weeks, showing no tendency to diminish, you may very properly resort to paracentesis in order to shorten the duration of the case, and so lessen the risk of collapse of a portion of the lung.

With regard to the spot chosen for puncture, you may take it that the fifth or sixth interspace, according to circumstances, in the mid-axillary line is as good as any. I have several times seen chests tapped in the line of the inferior angle of the scapula without fluid being struck, a different result ensuing when a second attempt was made in the axillary region. Fraentzel also states that this is not an uncommon event, and the most obvious explanation is that when the posterior puncture is made it is at a lower level, where the cannula is more likely to be entangled in flakes of coagulated fibrin adherent to the wall of the thorax.

Then, as regards the course of the operation, I should say that it is best to remove the fluid very slowly. It is not possible, even if it were desirable, to remove it all, but you can withdraw more with greater comfort to the patient if the withdrawal is done very gradually.

Paracentesis is feared by some on account of the supposed risk of its being the means of changing a simple serous effusion into a purulent one. It is difficult to see how this can happen from the mere removal of some of the fluid. It may possibly result from the use of unclean instruments, but for this there is no excuse, and it would not form the ground of any valid objection to the operation. As a matter of fact, I have never seen it occur, and it may very fairly be suggested that the cases where it has happened were doomed to become empyemata whether they were tapped or not.

One thing more I would say in connection with the indications for tapping—namely, that you need not be deterred, as has sometimes been said, by a high temperature. You may practically disregard temperature altogether, for I believe you will almost always, in the

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case of serous effusion at least, find the temperature to fall after removal of fluid.

CASE 3. *Pleurisy of left side, with moderate effusion; treatment by tonics, iodide of potassium, cod-liver oil, and blistering; rapid recovery.*—The patient here was a male, aged thirty-two, a porter, who came into the hospital on Jan. 2nd, 1885. He states that he had been ailing for about six weeks, and complained of cough, shortness of breath on exertion, and occasional night sweats, with some pain in the left side. On admission his temperature was only 97.8°; pulse 76; respiration 20. I may state briefly that he presented all the more important signs of a very moderate effusion, and as he was quite comfortable while at rest, and I knew that the effusion was not increasing from having seen him previously in the out-patient department, his case seemed a suitable one for less active treatment than those previously recorded. He was accordingly given quinine, iron and iodide of potassium, with a blister to the left posterior base, and in a few days he began to manifest improvement. A week after admission it was noted that there was less impairment of resonance, and the breath sounds could be faintly heard down to the extreme base. After eight days more he was discharged convalescent, the breath sounds towards the base being still less than normal, and the resonance somewhat impaired, but otherwise well and comfortable.

CASE 4. *Pleurisy of right side with slight effusion; strapping of side for the relief of pain; treatment otherwise by tonics, iodide of potassium, and cod-liver oil; rapid improvement.*—This case was also that of a male, twenty-eight years of age, a bootmaker by occupation, of pasty complexion and anxious expression, who was admitted about the same time as the last, complaining of a sharp shooting pain in the right side of his chest, aggravated by deep breathing. His temperature was 100.2°; pulse 80, of pretty good quality; respiration 24, shallow and catching. Friction sounds were very plainly heard over the lower third of the right lung, with some impairment of resonance. The chief thing to deal with in this case being the pain from which he suffered, strapping was applied to the right side, and this gave him speedy relief. A slight amount of effusion took place; his temperature fell, and he became rapidly convalescent. He was discharged ten days after admission free from cough or pain, and with nothing to suggest the attack through which he had passed except some slight impairment of resonance at the extreme right base,

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with diminished breathing and decrease of vocal sounds. The medicinal part of the treatment consisted mainly of quinine and iron with cod-liver oil, and a cough-mixture while cough was a prominent symptom.

This last mentioned case introduces us to an element which was not marked enough in any of the other cases to require treatment—I mean the catching pain. This is a symptom which is often much more troublesome than it was even here. It was relieved in our case by the strapping which kept the inflamed pleural surfaces comparatively at rest. But where it is very intense I know of nothing which is so speedily followed by relief as the application of a couple of leeches. I have made no account of what I may call the minor signs of pleural effusion, because they are all comparatively unimportant, and all of them probably never present in the same case. There is one sign, however, which occupies a kind of middle position between these and the three chief signs referred to in connection with Case 1—namely, abolition of breath sounds. This sign was conspicuously absent in Case 2, in which breathing was heard all over the affected side notwithstanding the fact proved by the tapping that the pleura contained several pints of fluid.

In any case where you are in doubt as to the presence of fluid (and such cases must sometimes occur), you have always an *experimentum crucis* to fall back upon, that of exploring with a hollow needle attached to some kind of syringe. I would recommend you to keep one for the purpose, and use it for nothing else, the needle being slightly larger than those generally used for hypodermic injection. If the fluid should happen to be thick pus, it may not be found to run through a very small needle, and your doubts, instead of being resolved, may be intensified. It should be scrupulously cleaned after use by repeated washings with Condy's fluid or some similar solution, especially after exploring an empyema. Even if no fluid be present, its employment will do no harm beyond the pain of the prick. Its value was strikingly displayed in the case to which I shall next ask your attention.

Case 5. *Empyema in a child with retraction of the affected side; difficulty of diagnosis from physical signs alone; inodorous pus obtained on exploration; paracentesis; improvement; further exploration, fetid pus obtained; free opening and drainage; recovery.*—Louisa E. B——, four years of age, was admitted to the Northum-

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berland Ward on Jan. 9th last. She is the only child of her parents, both of whom are alive and healthy. Eight weeks before admission she was attacked by inflammation of the lung, according to the mother's account. She had a bad cough for the first four weeks, and since then she has been gradually getting thinner and weaker and more listless. her appetite being also very bad. On admission her temperature was 98°; pulse 100, and of fair quality; respiration 26; tongue slightly furred. She was a pallid, pasty, emaciated child, complaining of loss of appetite, weakness, and slight cough. The right side of the chest was retracted and flattened in front, and did not move at all on respiration. There was marked dulness on percussion below the second rib in front and below the spine of the scapula behind. Faint distant breath sounds of tubular quality were heard over the greater part of the dull area, being absolutely inaudible perhaps only in the axillary region. At the apex of the lung breath sounds were well marked; expiration prolonged. On the left side the respiratory movement was exaggerated as well as the breath sounds, and the percussion note was clear. The heart's maximum impulse was seen and felt in the fifth left interspace outside the nipple line, the sounds being perfectly normal. There was nothing abnormal observed about the abdomen, the area of liver dulness in particular not being depressed. The urine was normal. The finger ends exhibited the faintest tendency to clubbing. There was no diarrhœa or vomiting. A cyrtometric tracing taken of the chest about the nipple level showed well the difference in size and shape of the two sides of the chest. She was put upon cod-liver oil and steel wine with a nutritious diet, and, as her case presented no urgency, she was simply watched and re-examined from time to time to see if any change in the physical signs should take place. The temperature rarely exceeded the normal, having only twice reached 100° in ten days, and it was occasionally subnormal. In order to clear up the diagnosis, an exploratory puncture was made (Jan. 21st) in the fifth right interspace in the anterior axillary line, and pus of a light-greenish color and odorless was obtained. Having established conclusively the presence of pus, it was determined to remove it by means of the aspirator, washing out the pleural cavity with a warm solution of Condy's fluid. This was done on Jan. 23d while the child was under the influence of chloroform, the puncture being made in the fourth interspace in the anterior axillary line. About four

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ounces of pus were withdrawn, which, toward the end of the operation, was found to be slightly blood-stained. The physical signs were not very much changed, the most observable being that the breath sounds were a little more distinctly heard. In the evening the temperature was 104.2°; pulse 140; respiration 52. She passed a good night; but on the following morning it was noted that she had spat up a little bright blood, and during the day she was much troubled with vomiting. This vomiting continued more or less for three days, during which time the temperature varied between 98.8° and 103.6°, the highest records being at 10 P. M. The cough was rather troublesome. Indeed, it was this that was probably mainly responsible for the vomiting. Sweating also was noticed at intervals for several days, the physical signs remaining much the same as before. At the same time she slept well, and had a fair appetite. By Feb. 4th the temperature was but little over the normal and the cough was better; and on Feb. 10th it was noted that resonance over the right back and front was not so much impaired as formerly, and breath sounds were fairly heard over the back, but both resonance and breath sounds were still much impaired in the axillary region, and she retained her pasty appearance, and did not obviously gain flesh. Accordingly, a few days later two exploratory punctures were made in a further search for pus, one at the seat of the former puncture, and a second two inches further back, this being the area of greatest dulness; but no fluid was found, and the impression conveyed by the movements of the needle was that its point was in solid lung and not in a cavity. About this time it was also noted that the heart's apex was within the nipple line.

Notwithstanding the negative result of these explorations, and as she did not improve as I thought she ought to have done unless pus were still present, I made another exploratory puncture on March 12th, in the seventh interspace behind the angle of the scapula, and withdrew a syringeful of very offensive pus. It seemed obvious now that the proper course was to freely incise and drain the pleural cavity, and accordingly, on March 14th, this was done by Mr. Morris at my request, an inch and a quarter of the eighth rib in the line of the angle of the scapula being removed and two drainage tubes introduced after the evacuation of about four ounces of very fetid pus. The pleural sac was irrigated with a weak warm solution of iodine, and the wound enveloped in cotton-wool and gauze. In the evening

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the temperature rose to 101.6°, and remained more or less febrile for five days, during which there was a considerable amount of pus discharged. After this the discharge diminished daily, the temperature became regularly normal, and the child gained flesh and color rapidly. She was put into a warm bath containing Condy's fluid every day, so that she washed out her own chest after the manner recommended by Dr. Barlow and Mr. Parker. By April 17th the discharge was so slight that the drainage tube was then removed and the wound allowed to close. A note made about three weeks later stated that the child was fat and of an excellent color. There was very slight drooping of the right shoulder; resonance and breath sounds were somewhat impaired at the extreme base of the right lung, elsewhere both were fairly normal. The heart's maximum impulse was apparent just under the nipple in the fourth interspace, the sounds being normal. In this condition she was discharged on May 19th.

The first point to which I wish to direct attention, in connection with this case, is the difficulty which beset the question of diagnosis apart from the crucial test of exploring the pleural cavity. I do not here refer specially to the retraction of the affected side, which in such cases is not very uncommon, but to the totality of the symptoms and physical signs, positive and negative, including the temperature, the absence of œdema of the affected side, of enlargement of superficial veins, of sweating, diarrhœa, and vomiting, these latter, however, appearing after some of the pus was removed. Two explanations of the case seemed possible, between which it was hard to choose; either that a simple serous effusion had existed, which becoming absorbed had left the lung partially collapsed and the chest wall retracted; or, as was ultimately proved, that the case was, notwithstanding doubtful points, one of empyema. In the latter case I presume that the retraction of the side must be explained, in the same way as in the event of a simple serous effusion—namely, that the more absorbable parts of the fluid had been absorbed and left the lung in a state of collapse, and it was probably because the pus was perfectly sweet that this absorption had not given rise to diarrhœa and sweating. From, the first, however, I rather inclined to the diagnosis of empyema, for these reasons: the tubular breathing over the dull area was less well-marked than might have been expected, apart from the intervention of fluid between the lung and the chest wall; and the pallid and pasty appearance of the child, and the appar-

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ent clubbing of the finger ends (although this last was exceedingly slight, so slight, indeed, that at first I was in doubt as to whether one could say that clubbing was present at all), were chiefly suggestive of empyema. Even in presence of these signs, however, I hesitated to make an absolute diagnosis till the use of the exploring needle removed all doubts. Regarding the treatment of such cases we have a choice of two methods: aspiration, which may have to be two or three times repeated, or a free opening and drainage. The former was decided upon here in the first instance as being a less formidable proceeding, leaving the free opening in reserve if it should prove to be necessary.

Treatment by aspiration is more applicable in the empyema of children than it is in that of adults; but, after all, children, as a rule, do so well where a method of free incision has been adopted that one is sometimes left in doubt whether it would not be as well to have recourse to it at first.

With respect to other than operative treatment in such cases, cod-liver oil and iron in some form are our mainstay. When this child's temperature became high and sweating came on, I ordered her quinine and dilute sulphuric acid, and when troubled with the vomiting the cod-liver oil was discontinued. When the cough became a prominent symptom, she had a cough mixture containing a small quantity of ipecacuanha wine, tincture of squills, aromatic spirit of ammonia, and glycerine, which seemed to do her some good. But the chief thing, of course, is to get rid of the pus.

In comparing the methods of aspiration and free opening for its evacuation, I would add that the former is only applicable where, as in the present case at first, the pus was sweet. If it should prove to be fetid, as it latterly became, the proper course is to have it removed by a free opening and the pleura efficiently drained without delay.—*D. W. Finlay, Lancet, Sept. 26th, 1885.*

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Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

FORMULÆ.

FOR RHEUMATISM.

℞ Guaiaci(vit. ovi semel) ..... ℈ j
Aquæ dest. ..... ℥ j
Liq. ammon acet. ..... ʒ ij
Syrupi ..... ʒ j

M.—For one dose.

—Dr. E. J. Clark.

A DIURETIC AND ANTILITHIC.

℞ Lithiæ citratis ..... gr. x
Acidi citrici ..... gr. xx
Syr. auranţii ..... ʒ ss
Aquæ ..... ℥ ij

M.—To be taken in a state of effervescence with fourteen grains of bicarbonate of soda dissolved in two ounces of water.

—Dr. Guy.

FOR OBSTINATE INTERMITTENTS.

℞ Quiniæ kinatis .....
Piperis nigri .....
Ext. absinthii ..... aa.... ʒ j

M. et ft. pil No. lx. Sig. Two pills every two or three hours.

—Ronander.

TO PRODUCE DIAPHORESIS IN FEVERS.

℞ Inf. serpentariæ ..... ʒ ix
Ammoni carb. ..... gr. v
Syrupi ..... ʒ j

M.—Sig. To be taken twice daily.

—Dr. Paris.

FOR UTERINE FIBROIDS.

℞ Hydrarg. perchlorid ..... gr. 1-12
Ext. belladonnæ ..... gr. 1-6
Ext. gentianæ ..... gr. iv

M.—Make one pill. Sig. One twice a day.

—Dr. R. Greenhalgh.

COLCHICUM MIXTURE.

(Used in Great Northern Hospital, London.)

Take of—

Wine of colchicum ..... minims 15
Carbonate of magnesia ..... gr. 10
Sweet spirits of nitre ..... minims 20
Tincture of henbane ..... " 30
Spearmint water ..... to..oz 1

Mix.—For one dose.

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GILLFORD'S SOLUTION BROMIDE OF ARSENIC.

Take of—

Arsenious acid	gr. 60
Carbonate of potassium	gr. 60
Bromine	fl. dr. 2
Water	q. s.

Mix.

The carbonate of potassium and arsenious acid with four ounces of water are made into a solution by aid of heat; when cold, the solution is made up to twenty ounces, and to this the bromine is added.—*Pharmaceutical Record.*

This is one of the best solutions of bromide of arsenic used in diabetes melitus. The dose is from two to ten or twelve drops in a little water, to be taken after each meal. We have nsed this preparation in a number of cases with wonderful results. Of course, the diet must be regulated according to rule.—*Physician's and Surgeon's Investigator.*

WARBURG'S TINCTURE.

The following is said to be Dr. Warburg's own formula, first published in 1875: Take of—

Socotrine aloes	lb. 1
Rhubarb (East Indian)	oz. 4
Angelica seed	" 4
Confect. of damocratis	" 4
Saffron	" 2
Fennel seed	" 2
Prepared chalk	" 2
Gentian	" 1
Zodoria	" 1
Cubeb	" 1
Myrrh	" 1
Camphor	" 1
White agaric	" 1

Mix.

These ingredients are to be digested with 500 ounces of proof spirit in a water-bath for twelve hours, then expressed, and ten ounces of quinine sulphate added, the mixture to be replaced in the water-bath till all the quinine is dissolved. The liquor when cool, is to be filtered, and is then fit for use.

CARBOLATE OF IODINE INHALANT.

The following is said to be similar to Cutler's: Take of—

Compound tincture of iodine	minims 180
Carbolic acid No. 1	" 48

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Glycerin ..... fl. dr. 1
Water ..... fl. dr. 5

Mix and expose to the sunlight until the mixture is entirely colorless.

The proportion of carbolic acid and tincture of iodine may be largely increased without a corresponding addition of glycerine.—*National Druggist.*

COMBES' APERIENT.

Take of—

Sulphate of magnesium ..... parts 35
Roasted coffee ..... " 40
Boiling water ..... " 500

Mix.—Boil for two minutes, sweeten to taste with white sugar. Dose, one wine glassful in the morning.

FOR FRECKLES.

℞ Hydrarg. perchloridi ..... gr. xij
Sp. rect ..... ʒ ii
Aq. dest ..... ʒ vj

Ft. lotio.

This solution, dabbed onto the parts two or three times a day, is very efficacious.

DEPILATORY CAUSTIC.

(Used in British Skin Hospital, London).

Take of—

Sulphuret of calcium ..... dr. 1½
Oxide of zinc ..... dr. 6
Carmine ..... gr. 1

Mix.—Used as a paste with water.

Class-Room Notes.—From the *College and Clinical Record.* In wounds upon the face, Prof. Gross covered the sutures with solution of iodoform ten parts, collodion ninety parts.

—Prof. Gross says: When we find a heavily coated, furred tongue, give grs. iij calomel, followed by ʒ ij each, of Rochelle and Epsom salts.

—In gastralgia Prof. Bartholow has often obtained good results from—

℞ Atrophiæ sulph ..... gr. j
Zinci sulph ..... ʒ ss
Aquæ destil ..... f ʒ j

M. Sig.—Three to five drops twice or thrice daily.

—The lead water and laudanum solution of Prof. Gross is as follows:

℞ Plumbi acetatis ..... ℈ ij
Tr. opii ..... f ʒ ss
Aquæ ..... f ʒ viij

M. Sig.—Lotion.

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A young man who had for several years practiced masturbation, applied to the clinic for relief, as he was suffering from a *morbid sensibility of the urethra*, with constant, sticky discharge from that canal. He was given by Prof. Gross—

℞ Potass bromid.....ʒ j
Sodii bicarb.....gr. xv
Inf. digitalis.....fʒ ss
Atropinæ sulph.....gr. 1-60
M.—Sig. At bedtime.

In a case of cerebral hyperæmia consequent upon a blow, Prof. Da Costa prescribed the following active purgative:

℞ Ext. colocynth.....gr. j
Capsici.....gr. ½
Ext. gentianæ.....gr. ij
M.—Sig. Ter die, in pill.

At night, sodium bromide, gr. xxv.

A man, 63 years old, suffering from mitral stenosis with hypertrophy, and in whom atheromatous degeneration of the blood vessels was present, was given by Prof. Da Costa, fluid ext. of convallaria, gtt. viij ter die, to make heart beat more regularly; Fowler's solution for the atheroma.

A boy, four years old, had recurring spasms. Two years previously he fell, striking on his temple, causing instant paralysis on opposite side. Was given by Prof. Da Costa—

℞ Potass. iodidi.....gr. iij
Potass. bromid.....gr. v
Elix. aurantii.....ad....fʒ j
M.—Sig. Ter die.

To prepare his ligatures for use, Prof. Gross uses McCuen's method: Take ʒ j of chromic acid (crystals) to fʒ v of water. Of this solution take fʒ j and add to it fʒ v of glycerin. In this latter steep the animal ligatures for ten days, then remove and thoroughly dry them. Now, for preservation, keep them in a 5-100 solution of carbolic acid.

For a case of infantile paralysis of two or three weeks' duration, in a girl æt. 4, in which the paralysis involved the right upper extremity and the left lower extremity, Prof. Bartholow brought about a good result by massage, also the administration of lacto phosphate of calcium with ol. morrhuæ. Strychnia was injected into the muscles.

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Dr. Sajous, at the hospital, treats post-nasal catarrh as follows: First, a purgative, as sulphate of magnesia, ℈ ij; then use as a "snuff" ter die—

℞ Bismuth subcarb.....
Pulv. acaciæ.....aa....ʒ ss
Zinci sulph.....gr. x
Morph sulph.....gr. ij M.

At the hospital, Dr. L. Webster Fox prescribed for a case of acute conjunctivitis:

℞ Acid borici.....gr. xij
Aquæ camphoræ.....
Aquæ destil.....aa....fʒ ij

M.—Sig. Eye lotion.

Should this fail, use something stronger, as zinc chloride, gr. ij to fʒ j. In the third stage, where we are confronted with granular lids, use the caustic copper, in sticks.

Dr: Fox also spoke of jequirity in troublesome granular lids, to-wit: Bruise ʒ j of the beans to a pint of water. Take a little of this solution and apply to the eye, and in a week we obtain a smooth surface.

To diminish the sensibility of the mucous membrane of nose, Dr. Sajous uses—

℞ Acid. tannic.....gr. xl
Glycerini.....fʒ j

M.—Sig. Apply with a cotton-wrapped probe.

A solution of zinc chloride, gr. ij to fʒ j, is also useful, or gr. v to fʒ j, of the zinc sulpho-carbolate.

To get rid of effusion when the above is of no avail, let the patient sit covered with a sheet, and place a lamp within to steam him; or use—

℞ Bismuth subcarb.....
Pulv. talc.....aa....ʒ j
Aluminis.....ʒ ss
Morph. sulph.....gr. j
Pulv. acaciæ.....ʒ j

M.—Sig. To be used as a snuff several times a day.

The following treatment, by Dr. Sajous, was recommended for chronic coryza:

℞ Sodii salicyl.....ʒ ij
Sodii bibor.....ʒ iij
Glycerini.....fʒ ss
Aquæ.....fʒ vj

M.—Sig. Of the above take fʒ ij and put into Oj warm water (100° F.).

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Of this latter solution "snuff" into nostrils as much as can be taken up in the hollow of one's hand, ter die.

Prof. Bartholow advised, in a case of catarrh of the nares, of specific origin—

℞ Sodii iodidi.....gr. x
Syrupi picis.....fʒ ij
M.—Sig. Ter die,

Also—

℞ Pil. ferri iodidi (U. S. P.)
Sig. One daily.

In the management of pregnancy, Prof. Parvin spoke as follows: Let the patient eat but little in the latter months, though she may eat a little frequently during the day. A large meal causes much inconvenience, due to the already enlarged abdomen. A bandage properly applied around the abdomen is useful and comfortable. She should sleep eight hours and take an occasional bath in tepid water. If leucorrhea be present, let her use an injection of salt water, and bathe the external genitalia with tepid water.

Care of the breasts.—Use oily matters, and no alcohol. In the morning the nipples may be painted with equal parts of tinct. arnica and water, but in the evening should be covered with cocoa butter.

High-heeled shoes should be dispensed with during pregnancy.

Iodidide of Potassium in the Treatment of Uterine Hemorrhage.—Dr. Pan Alexopocelos contributes an article to the same journal on some observations made in the treatment of uterine hemorrhage with iodide of potassium. He calls attention to the fact that these hemorrhages are often idiopathic. that is to say, no cause can be found except in the general condition of the individual. Very often they are induced by vestiges of a para—or perimetritis which was not discovered by an examination, but which proved to remain as a source of irritation whence, by reflex action, the ovaries and uterus become the seat of congestion—organs which are productive of hemorrhage.

Substances which cause a disappearance of these points of irritation by bringing on a resolution of this exudation, act in the manner of hæmostatics. To the author, iodide of potassium seemed to meet this indication better than any other remedy, and he cites three cases in proof.

The first case was a married lady, 50 years of age, who never had any children. She suffered for three years from profuse hemorrhage, which returned about every third day. In consequence of this loss

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of blood she was very pale and anæmic. Little or no appetite, habitual constipation, but no disease of heart or lungs. The patient complained of great pain at sexual intercourse, and a constant pale discharge. The author, who had not examined the uterus, regarded this as a case of metritis with chloro-anæmia. He at first prescribed a light purgative, followed by preparations of iron which were used for fifteen days. The constipation was overcome by means of aloes and rhubarb.

The hemorrhage, however, persisted. He then ordered iodide of potassium in an infusion of arnica, to be taken every morning while fasting. From that time he obtained very good results. Four or five days after the administration of this remedy in large doses, the patient said her hemorrhage had ceased and she felt no pain and was perfectly well again. Along with the iodide he prescribed also an infusion of hops. He advised the patient to continue this treatment and gradually increased the dose of the iodide of potassium until she took double the original quantity. She had been upon this treatment one month when she felt the return of severe colicky pains; she thought that her menses were coming on and stopped all medication. On the following day she had a white flow. Since that time Mrs. A. S. has been well; her menses and hemorrhages have ceased, she only has some pale discharge and the constipation remains, due probably to her occupation, that of a dress-maker.

The second patient was a lady forty years of age, the mother of three children, of whom the oldest was twenty-three years of age. She had suffered from profuse hemorrhage, followed by extraordinary emaciation in consequence. During the time of menstruation the patient felt slight pains in the dorsal region, but her general condition was good. By means of touch or use of the speculum nothing could be found on the part of the uterus. Presently the hemorrhage came on again; on the first day of her menses it was nothing unusual, but on the second she fell in collapse and the blood flowed as from a fountain. The patient estimated the quantity of blood lost that day as amounting to about two litres. The hemorrhage lasted eight days. Once this period passed and the patient seemed to regain her health, was joyful, and had a good appetite.

The use of all kinds of astringents had been powerless in checking this flow. Three days after the cessation of the menses the author ordered three drops of tincture of nux vomica and four drops of dia-

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lyzed iron per day, to be taken together at meal-time. After the patient had been strengthened by this treatment for eight days, iodide of potassium was administered and continued for three months. During this time the menses were suppressed and replaced by a slight discharge. From this time on the iodide was discontinued, the patient had regained a rounded figure and was in perfect health. The menses now returned regularly with a mean duration of three days.

The next case was of a different nature and yet the iodide of potassium had a good effect. A young woman 35 years of age had suffered during eight days from a sub-acute attack of metritis attended with hemorrhage for which she had tried all sorts of astringents before she was placed in the care of the author. She had high fever, one hundred and thirty-six beats of the pulse per minute. She had no motion from the bowels for five days, complained of violent pain in the abdomen, which was very tender and tympanitic. By means of touch the neck of the uterus was found enlarged and painful. The speculum revealed a slight ulceration which disappeared after a few repetitions of the local application of nitrate of silver. The patient also had a frequent desire to urinate.

The metritis was treated at the start without much of a result by means of palliative and emollient remedies. Iodide of potassium was then administered and the alleviation soon appeared. The next day the patient was better and an examination disclosed a marked diminution of the swelling. The ulceration was also very limited.

This treatment was continued for a few days when the patient became perfectly well and no longer felt any pain. W. H. W.

Menthol.—Our German confreres have of late extolled the virutes of menthol as an antineuralgic agent, and still more recently, experimenters point it out as a substitute of cocaine in local anæsthesia. In solution, in alcohol or oil, in the proportions of from twenty to fifty per cent. According to Rosemberg, of Berlin, menthol produces anæsthesia exactly as cocaine, which lasts from fifteen minutes to one hour, or one and a half hours and even two or three hours, if the applications are sufficiently repeated. These solutions have been applied to the nares, pharynx, larynx, trigeminal neuralgia and odontalgia, with excellent anæsthesic effects.

Baratoux's experience does not coincide with that of Rosemberg, in affections of the nose and throat, in the proportions of from twenty

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to fifty per cent, incorporated with petrolatum, he finds it a rather efficient anæsthetic, inferior, however, to cocaine, although its action upon the mucous of the eye is better defined than upon that of any other organ.

Obstetrics and Gynecology.

Edited by E. P. MURDOCK, M.D., 179 South Sangamon St.

Biniodide of Mercury as a Disinfectant in Obstetrics.—At a meeting of the Obstetrical Society of Philadelphia, Dr. Bernerdy presented a paper advocating the use of this substance as the most powerful antiseptic.

D. Miguel published the results of some experiments made to determine the minimum amount of a disinfectant necessary to prevent fermentation in a litre of sterilized beef-broth. Mercurials are the best antiseptics, and the biniodide about three times as strong as the bichloride. To a litre of sterilized beef-broth he found it required .025 gramme of the biniodide, while .07 gramme of the bichloride were necessary to prevent fermentation, which would be 1-40,000 part for the biniodide and 1-14,000 part for the bichloride. He determined to give the biniodide a trial in obstetric cases, where an antiseptic was required.

CASE 1. Mrs. D., plupara labor rapid, had an extensive laceration of the perineum. No sutures were inserted. On the third evening she had severe frontal headache and chills, followed by fever and great tenderness over uterus. There being no improvement in her condition, her medical attendant was discharged, and another called in who gave such an unfavorable prognosis that he too was requested to cease his attendance. At the end of six weeks when Dr. B. was called. The patient had well-marked symptoms of septic poisoning. Pulse 130 to 140, small and thready, and easily compressible; temperature 104°, to 105°; slightly delirious; constant vomiting; abdomen swollen and excessively tender; uterus enlarged and extending, fully three inches above pubis. In the right side there seemed to be a growth extending up into the abdomen—tender on pressure. Os dilated, issuing highly offensive matter, uterus surrounded by organized lymph and immovable. The vagina was hot and perineum torn to the anus, the surface raw and secretion acrid, which scalded the surrounding integument.

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In conjunction with internal treatment intra-uterine injections of bichloride of mercury 1-2,000 were used, three or four times daily. This was continued for three or four days without any marked results. The discharges continued offensive. On the fourth day injections of one to four thousand of a solution of biniodide were tried. Within twenty-four hours an amelioration of all the symptoms took place, the pulse fell to 100; temperature 101°; discharge no more offensive. The injections were continued for ten days, gradually reducing their frequency. The uterus returned to its normal size, lymph absorbed, and the patient recovered.

Two more cases are reported with almost as startling results. His results are decidedly in favor of the biniodide. With so dilute a solution the chances of salivation are reduced to a minimum.

[The doctor's method of making the solution is: Take three and a half grains of the salt and triturate in a mortar with one quart of boiling water slowly added, giving solution of one to 4.390. I have been using a concentrated solution in iodide of potassium and find it just as efficient. I prescribe it as follows:

℞ Sodii chloridi..... ʒ i
Hydrarg. bichloridi..... ʒ i
Potass. iodidi..... ʒ ij
Aquæ dist ..... ℥ ij

M. Sig.—One teaspoonful in one quart of warm water, use as a wash, this forms biniodide of mercury and holds it in solution of iodide of potass.—Ed.]

Severe, so-called "uncontrollable vomiting of pregnancy (Graily Hewitt, Transactions Obstetrical Society, of London, vol. xxvi.)

The effort in this paper is to determine the cause of vomiting. From a careful analysis of the reported cases he reaches the conclusion that the cause resides in the uterus itself, and broadly stated, prevents the due and normal expansion of the uterus. The chief factors preventing such expansion are versions and flexions, and denseness or rigity of the cervical tissues.

Dr. Hewitt proves his conclusions in two ways, first by an analysis of those reported cases in which the only apparent cause of vomiting was versions, or flexions, or rigidity, and second by the results of treatment. The position he assumes is no new one, and while his later experience has slightly modified his views in regard to flexion as a universal cause, it has simply strengthened his belief in the uterine origin of vomiting. In this paper he has constructed two tables con-

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taining analysis, first of all the reported cases of vomiting wherein the state of the uterine body was noted, and second, wherein the cervix as regards rigidity or abnormal conditions of the os were the apparent factors. In regard to this factor, rigidity, Hewitt claims that, whilst *per se* it is of importance, there is reason to believe that rigidity alone would rarely occasion serious symptoms, were it not associated with uterine distortion.

The results of treatment lead to the same conclusions. The displacement being overcome, the distortion corrected or in the last case the cervix dilated carefully before the patient's weakness is so extreme that the question of treatment is no longer a choice, but of necessity. She experiences such relief as to convince any observer of the correctness of the causation theory of this paper.

Hystero-Mania—Laceration of the Cervix.—*Gentlemen:—Our first patient this afternoon is thirty years old; married; has had one child, or rather a premature labor at almost the seventh month; menstruated first at fourteen years, and was in fair health except that the menstrual flow was scanty and irregular. After marriage the nervous symptoms grew more and more aggravated at each epoch till pregnancy, after which her health became bettter and remained so until after the accident which resulted in the miscarriage. Succeeding her confinement, she got up, slowly, but seemingly felt quite well for a while, but at the return of menstruation the old symptoms returned, and have been growing more and more aggravated ever since. As the time approaches for the menstrual flow she becomes irritable, dazed and absent-minded, and at times, consciousness is entirely lost, and she is unable to give any account of herself—the severity of the symptoms being inversely in proportion to the amount of the flow.

Some of the class will remember a patient woh was in the clinic last spring with a similar class of symptoms, save that she had never been pregnant. In that case the patient was picked up during one of her paroxysms and adjudged insane, and actually placed in the asylum, where the nature of the case was recognized, and she was immediately released and sent here. I found a uterus undeveloped, almost infantile, stenosis of the internal os, and general congestion of the pelvic tissues. The cervix was dilated with a tupelo tent, and the insanity disappeared as by magic. Now, that is just what we propose

*Clinical Lecture, delivered at the Hospital of the Chicago College of Physicians and Surgeons, by E. P. Murdock, A.M.,M.D., Lecturer on Gynecology.

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to do in this case. This patient, however, has been pregnant, still I find a severe stenosis, which unquestionably is cicatricial in its nature. In addition, I find an anteflexion due to incomplete involution after confinement. This partial subinvolution is due in this case to the injury to the cervix at the time of parturition, and the cicatricial stenosis is due to the same cause.

This woman has been living in wedlock eight years since the confinement referred to, and has been barren. Now, if we can stimulate a healthy action in these pelvic organs, relieve the stenosis by proper dilatation, we may increase the menstrual discharge, relieve her sterility, and cure her insanity.

She came into the hospital this morning, and I introduced a tent, after making an incision, to partially enlarge the canal of the cervix, and now I will remove that tent before the class; the patient will be kept in bed a few days, and we will report the progress of the case to you at some clinic in the near future.

Laceration of the Cervix.—This patient is being etherized for the purpose of an operation. She is twenty-six years of age, married; has had three children, the second was a foreceps delivery. After that confinement her recovery was very slow, and from that time she dates her ill health.

Her appetite is poor; and her bowels constipated. She suffers from vertigo; palpitation of the heart; severe headaches, pain in the back, and extreme languor. Menstruation regular every four weeks, profuse in amount, lasting from seven to thirteen days, with an occasional intermenstrual hemorrhage. The cervix is deeply lacerated, bilaterally, the surface excoriated, bleeding on touch, and covered with a thick, tenacious muco-purulent discharge. The uterus is large, heavy, and lies low in the pelvis, and a free hemorrhage follows the introduction of the sound.

The patient being placed in the exaggerated lithotomy position, and the perineum being depressed by a Sims' speculum, we seize the cervix with vulsellum forceps, and bring it down to the vulva, and now you can easily see the nature and extent of the laceration. I first deepen the laceration by removing the cicatricial tissue in each angle, then pare the surfaces thus, and the two lips fit perfectly together. By means of this rectangular needle which is threaded after the point has been passed through both lips; the needle being quickly

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withdrawn, and the stitch is planted in this way. We introduce three on each side. I use in this case the No. 3 catgut.

Before tying the sutures, I will use a curette on the endometrium, and remove a mass of polypoid excrescences which have the appearance of profuse watery granulations seen upon the surface of an irritable ulcer. These, no doubt, furnish the cause for the hemorrhagia.

The stitches are now securely tied, and the operation is completed. The patient will be kept in bed about seven or eight days, and usually needs but very little attention. The stitches being catgut need no attention, as they will break or absorb and come away in the course of one or two weeks.

Dermatology.

Edited by HENRY J. REYNOLDS, M.D., 2200 Michigan Ave.

American Dermatological Association.—Ninth annual meeting. held at Greenwich, Connecticut, August 26, 27 and 28, 1885.

WEDNESDAY, AUG. 26—MORNING SESSION.

The meeting was called to order at 10 o'clock by the President, Dr. W. A. Hardaway, of St. Louis.

Dr. J. E. Graham, of Toronto, Canada, reported

A CASE OF TUBERCULO-ULCERATIVE SYPHILIDE OF HEREDITARY ORIGIN.

The patient was a girl 20 years of age. On the right arm, from the wrist to the elbow, there was very little healthy skin, there being little but cicatricial tissue. The skin of the forearm presents elevations and depressions, and in places it is covered with thin scales. The head is not involved, and the affection does not extend deeper than the subcutaneous areolar tissue. For three or four inches above the elbow the arm is atrophied and covered with cicatricial tissue. At the npper border of the cicatricial tissue there is an ulcer three-fourths of an inch wide, which encircles the arm. Above this is sound tissue. No nodules are present. The left clavicle presents about its middle a swelling and ulceration about the size of a silver dollar. This was the result of a blow. There is no copper-colored appearance. The heart and lungs are healthy and the urine normal. Investigation of the family history showed that the mother was apparently healthy. Three of the patient's sisters, all younger than herself, were healthy.

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The father died from pneumonia when the patient was eighteen months old. It was subsequently learned that he also had syphilitic ulceration of the throat.

The treatment consisted in the local application of a mild mercurial ointment, and the internal use of bichloride of mercury and iodide of potassium. The condition steadily improved, and in the course of six or eight weeks the ulceration had healed. The patient at that time passed from under observation.

The speaker referred to the difficulties of diagnosis in this case, as there was a complete absence of specific history, the facts in regard to the father not being learned for some time after the case had been under treatment. There was no history of any previous evidence of hereditary syphilis, but taking all the facts into consideration, the doctor thought there could be no doubt as to the correctness of the diagnosis. Photographs showing the condition were exhibited.

Dr. R. W. Taylor, of New York, thought that it is now generally conceded that syphilis can be communicated to the child without infection of the mother, and he believed that he was the first one in America to call attention to this fact. He had seen this a number of times, and in cases where a most careful examination of the mother had been made, and the observations continued over a series of years. The doctor had stated that he could obtain no history of early manifestations of hereditary spphilis. This was not uncommon, but he believed that there is usually some indication of specific taint, which, however, may be so slight as not to excite notice, or its exact import is not recognized. These may pass away, and in the course of six months or a year the ulcerative lesions appear, but it is not uncommon for the child to go to the age of from six to eighteen years without exhibiting this condition.

Dr. C. Heitzmann, of New York, thought that everyone has seen cases similar to the one reported. He had seen such cases in which he was unable to determine at first sight the nature of the affection. The diagnosis lies between syphilis and scrofula.

Dr. Greenough, of New York, said that he would like to refer to the practical point to which Dr. Taylor has called attention, and that was the possibility of the father infecting his progeny, without the mother showing any signs of syphilis. Within the past two months he had seen a woman who had lost three children in succession from hereditary syphilis, yet she was strong and apparently perfectly

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healthy, and had never shown any signs of syphilis. This woman had been under observation for six or seven years.

Dr. L. A. Duhring, of Philadelphia, thought that there are certain cases in which it was almost impossible to express a positive diagnosis at first. The result of treatment in causing a rapid cure in the case described would certainly incline him to the opinion that this was a case of syphilitic disease.

Dr. James Nevins Hyde, of Chicago, said that he had seen cases that convinced him that whilst it is not the rule, still, occasionally, syphilitic children are born where, so far as observation can be made, no evidence of syphilis in the mother can be detected. As far as the general health is concerned, the women are usually pallid and weak, although there may be no symptoms which can be ascribed to syphilis. He had never seen inherited syphilis manifesting itself in advanced years. The more he saw of syphilis, the more he was satisfied that in its origin, heredity does not amount to very much. The accidental cases of syphilis are very common. He had seen the initial lesion of syphilis on the head of a penis where it was unquestionably due to inoculation from the finger of the surgeon in catheterization. He had no doubt the case described was one of syphilitic trouble, and as Dr. Duhring had said, the result of treatment unquestionably points in that direction. No cases yield so readily as old cases of untreated syphilis. As to pronouncing it a case of hereditary syphilis his experience would not permit him to do so.

Dr. W. A. Hardaway, of St. Louis, thought that it is unwise to base diagnosis on the results of internal treatment. Because a case gets well under anti-syphilitic treatment is not proof that the affection is specific in its nature. Local treatment is often all that is necessary.

Dr. R. W. Taylor said that Dr. Hyde had made the statement that these women, apparently un-syphilitic who have born syphilitic children, have in his experience been pallid and weak. He entirely disagreed with him on that point.

Dr. F. B. Greenough, of New York, then read some

CLINICAL NOTES ON PSORIASIS.

The paper was founded on the records of 394 cases of psoriasis. This number occurred in about 15,000 cases of skin disease examined, and represented about two and one-half per cent.; 205 cases occurred

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in males and 188 in females. Several tables of statistics were presented, showing when the cases first came under observation and the age at which the attack was first observed. A large proportion of the cases was first attacked with psoriasis between the ages of ten and forty years, but the fact that one-seventh of the cases showed psoriasis before the age of seven years was not in accordance with previous observations. In 97 cases the speaker had been able to get reliable evidence in regard to the family history. In 31 cases psoriasis had existed in a near relative, but in 66 cases the patients felt sure that the disease had existed in no other member of the family.

As regards locality affected, where there is much development, it is almost constantly found about the elbows and knees, and more frequently on the extensor surfaces than on the flexor. There is one class of cases where the affection attacks only the skin below the knee. Well marked cases are readily diagnosticated, but in some cases there is considerable difficulty in making the diagnosis. It is most frequently confounded with some form of eruption resulting from constitutional syphilis. When psoriasis affects the scalp, its appearance is often similar to that of secondary syphilis. In psoriasis, however, the patch consists simply in epithelial cells and there is no hyperæmia connected with it. In syphilitic eruption, the crust will contain other elements than epithelial cells, and on removal of the crust, spots of moisture will be detected. A characteristic symptom of psoriasis of the scalp is a band of hyperæmia, about three-fourths of an inch wide, extending around the forehead, contiguous to the hair. This is a point of value in the diagnosis between eczema capitis and psoriasis. In the former affection this band is wanting. In eczema, also, evidences of dried serum or pus will be found. Psoriasis is not accompanied with enlargement of the post-cervical glands, as is eczema. The diagnosis from favus is made by the age of the patient, the evidences of the destruction of the hair follicles in favus and the microscopical examination. He had never been able to satisfy himself that psoriasis of the scalp ever caused permanent loss of the hair.

On the general integument, syphilides are most apt to resemble psoriasis. The regions upon which the eruptions appear is important. The syphilides are apt to affect the flexor surfaces, while the psoriasis affects more commonly the extensor aspects. Psoriasis begins as a minute point of hyperæmia, which may last for several days. In macular syphilide a crop of macules appear within twenty-four or

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forty-eight hours, when the eruption fades. There is in syphilis a decided pigmentary change. In squamous syphilis the epithelial scales differ from those of psoriasis. In some cases of psoriasis there is severe itching, leading to scratching of the skin, and as a result scabs and crusts make their appearance; but here the cause of the condition is readily recognized. The amount of pruritis complained of in psoriasis varies, but it is rarely a prominent symptom, although in exceptional cases it is very severe. He has never seen any eruptions on the hands or feet resembling psoriasis, with the exception of eczema, which was not syphilitic.

In regard to treatment, some cases do well, while others do not. There is no specific. What will benefit one case will make another worse. In his experience tarry preparations, especially the oil of cade, have been most efficacious. Great comfort may be afforded by the use of emolients. Cod-liver oil is one of the best applications. Cod-liver oil and the oil of cade (equal parts) is a common prescription. Chrysarobin is a powerful remedy, but has the disadvantage of destroying the clothing. On the face and scalp it is apt to produce dermatitis. The internal administration of arsenic in some cases is of benefit. Even after apparent recovery, there is great danger of relapse.

Dr. L. A. Duhring said that the reader of the paper, in referring to the diagnosis, did not allude to the difficulty sometimes experienced in diagnosing seborrhœa capitis from psoriasis. He had found considerable trouble in the diagnosis, particularly in young girls. In these cases the eruption was confined to the scalp.

Dr. A. R. Robinson said that in regard to the diagnosis of favus and psoriasis, there is usually no difficulty. He did not agree with the author in regard to one of his points of diagnosis. In the early stage you do not find moisture when the crust is removed. There is a shiny appearance. It is only in advanced stages that ulceration is present. He agreed with the speaker that psoriasis always occurs in small spots at first not covered with scales. While it is true that psoriasis often disappears without producing pigmentation, yet there may be discoloration found on the lower extremities, particularly where there is a varicose condition of the veins. In some cases where there are only a few patches of psoriasis, limited to the lower extremities, it is often difficult to make the diagnosis, unless there is involvement of other parts of the body, or you have the history. There are other cases

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of acute psoriasis which closely resemble acute eczema. In reference to the palms of the hands, whilst we do not see cases of psoriasis limited to this condition, yet he was sure that cases have been shown in which the palms of the hands have been affected in connection with other portions of the body.

Dr. J. C. White, of Boston, agreed with the previous speakers in regard to the difficulty of diagnosing between psoriasis of the scalp and seborrhœa. In some cases the diagnosis cannot be made for months. In all parts of the body pigmentation may follow psoriasis, but never over large areas. He called attention to one termination which he had seen in three cases, and that was a degeneration into epithelioma.

Dr. R. B. Morrison, of Baltimore, had seen a great many cases of psoriasis, but could recall only one or two cases of psoriasis in the negro. In such cases there is a loss of pigment.

Dr. G. H. Fox, of New York, thought that too much stress was laid on the general rule that psoriasis occurs most frequently on the extensor surfaces, the knees and the elbows. It is a notable fact that in general psoriasis, the vicinity of the knee and elbow escapes. Many cases of psoriasis occur in weakly subjects, while on the other hand, many cases of eczema appear in robust persons. In every individual case, the better the patient's health, the less likely is he to suffer from a recurrence of the affection. He had been very successful in the treatment of psoriasis, and in its management. He adopted the teaching of the late Tilbury Fox, who laid stress on the point that in psoriasis, as in other inflammatory affections of the skin, and also in lupus, the first thing to do is to lessen the congestion of the skin. He did this by restricting the diet. He cuts off the meat and orders a diet of fruits and vegetables in the summer, and in the winter gives a carefully restricted diet. Tea, coffee, tobacco, and stimulants of all kinds are to be cut off. By so doing more will be accomplished than is obtained by using arsenic and local applications at the start.

In regard to local remedies, he never uses tar in the treatment of psoriasis. With the application of chrysarobin made at the proper time, there is no necessity for the use of tar. He had seen many cases in which this drug did no good, but this was because the application was made when the patches of psoriasis were in a congested condition. If the acute congestion is lessened, chrysarobin will produce beneficial results.

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Dr. C. Heitzmann thought that one of the most important points after making the diagnosis is to decide as to the acuteness or chronicity of the affection. If it is acute, local applications are to be avoided. If the case is chronic chrysarobin may be used with advantage, at least temporarily. It is not a cure. He agreed with Dr. Fox that restriction of the diet is important for the purpose of lessening the congestion. Tar can not be dispensed with. Chrysarobin remedies the disease for a time, but in a few months it returns. There is nothing like tar to prevent the recurrence. No mention had been made of pyro-gallic acid, which does good in some cases. There are, however, some cases which can not be treated successfully with any remedies. The disease will steadily grow worse.—*Jour. Am. Med. Asso.*

(To be Continued).

Surgery.

Edited by G. FRANK LYDSTON, M.D., 125 State St.

Perforation of the Appendix Vermiformis—Treatment.—In the earlier cases of perforation of the appendix placed on record venesection seems to have been generally trusted to as the only means of cure. under the impression that the disease was of purely inflammotory character. It is scarcely necessary to say that such treatment proved of little benefit, inasmuch as the inflammation was the result of the introduction into the serous sac of a decomposing, or at any rate of an irritating material which no amount of blood-letting could remove. Its only effect was to lower the vital powers of the patient, and thus to diminish his chance of recovery by adhesion of the injured part to some of the neighboring organs. And other cases were treated by the use of drastic purgatives, on the supposition that the symptoms resulted from intestinal obstruction; but although in most cases the bowels were readily opened the fatal termination of the disease was not thereby obviated. On the contrary, the use of aperients proved to be so detrimental that they were entirely abandoned in this as in other forms of peritonitis. Of late years opium has been generally employed, but there has been no diminution in the mortality of the disease. I have prescribed it in every case that has come under my notice for some years, either alone or with belladonna; it has already relieved the pain, lessened or subdued the vomiting, given sleep, and

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proven an immense comfort to the patient, but in no single case has it appeared to avert the fatal termination.

Another plan of treatment has, however, been successfully adopted, viz: that of laying open the abscess formed around the perforation and allowing the pus to escape. The earliest case on record is one performed by Mr. Hancock, which ended in the recovery of the patient. Twenty years afterward Dr. Parker, of New York, operated upon a case successfully, and Dr. Gurdon Buck, of New York, has collected thirteen cases of this operation, of whom twelve recovered and only one died. I have twice advised this procedure. In the first case it was not performed until the patient was evidently sinking, but pus was found and evacuated; in the second, which was a very chronic one, the abscess was opened and recovery ensued. I have before mentioned that fluctuation can rarely be distinguished in abscesses of this kind, and out of ten reported by Dr. Buck it could be felt in only one, proving that there is no necessity to wait until this sign of abscess can be discovered. None of the above cases were operated on before the seventh day, and with one exception, the operation was not attempted until between the seventh and fifteenth day; but we have already seen that forty out of fifty-seven cases died during the first week of illness, so that if the rule should be followed, as has been hitherto laid down, of waiting until the pus is completely localized by adhesions, the operation will be restricted to a very small number of those who are attacked with this formidable malady. Theoretically it would seem to be much better if we could cut down upon the appendix as soon as the diagnosis was tolerably certain, tie it above the seat of the perforation and remove from its neighborhood any concretion or decomposing material that might be the cause of irritation. The only objection I can see to an early operation is that adhesions to the neighboring organs might be prevented; but when we reflect how very rarely the fortunate termination occurs, and how certainly death follows it if it does not take place, we may, I think, dismiss the objection from our consideration. But even when adhesion does result from perforation the fatal issue is in most cases only postponed, for, as we have before shown, the adhesions are often torn asunder by some undue exertion of the abdominal muscles and fatal peritonitis ensues.

Two methods of operation have been pursued: In one an incision has been made directly into the suppurating part and the pus at once

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evacuated; in the other the incision has only been carried down to the fascia, and either the pus has been allowed afterward to escape spontaneously or an aspirator has been passed into the most depending portion of the swelling, and the contents thus evacuated. It is evident, however, that if an operation were performed at an early period the incision must be carried down directly to the injured part, for we cannot suppose that pus would be formed and localized until many days after the perforation had taken place.

The choice of the method of the operation must of course be left to the discretion of the surgeon, and will probably require to be varied according to the circumstances of each case. Of one thing we may be quite certain, that no drugs are likely to be of much avail; for your common sense will tell you that when you have an irritating material suddenly introduced into a large serous sac the only chance of giving relief is to remove it, and thus put a stop to the original cause of the mischief. The office of the physician, therefore, will most likely become restricted to diagnosis, and it is only by carefully watching the first symptoms and the physical signs of the disease and by comparing them with those of other disorders that may simulate it that we shall be able to arrive at such a correct judgment as may justify the employment of surgical measures at an early period of the case.—*London Lancet.*

We are pleased to note the tendency upon the part of our transatlantic brethren, to interfere early in these cases. A recent paper before the New York Academy of Medicine upon peritonitis, by Dr. T. H. Burchard developed considerable discussion, which showed a decided predilection for earlier operative measures than have been hitherto practiced. We think that a good rule would be to make an exploratory incision as soon as a definite and œdematous tumor can be demonstrated. Should a sudden exacerbation of pain with increased tenderness on pressure and collapse occur, an operation must be at once performed, for such a combination of symptoms is pathognomonic of rupture of the abscess into the peritoneal cavity. As a rule, it is positively dangerous to wait for fluctuation before interfering.

Experimental Study of the Surgery of the Liver.—Surgery as limited to the surgical treatment of the liver has been very deficiently taught; generally with the forefinger carefully shaken, or a head-shake and a "let alone" lecture to wind up the story, as was the case with the

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surgery of the lung, until the year 1881, when, following experiments on dogs, a new field was opened to the knife.

I live in hopes that these experiments will "open sesame" the liver, so that if a surgeon should again, while making an exploratory gastrotomy, find a tumor of the liver, or a floating liver, he will remove the tumor or replace and fix the liver in its normal position, and not as heretofore, close up the wound, saying, "gentlemen, 'tis the liver," as though that were explanation enough for washing the hands of the case. Having seen a number of these cases "let alone," I began and carried out the series of experiments herewith submitted.

I will say further, that surgery of the liver, until recently, has consisted of aspirating pus cavities, or hydatid cysts, the knife never being passed into the liver tissue for fear of wounding the blood-vessels and thus causing death by hemorrhage (as we were not taught how to tie the vessels in the liver) or causing peritonitis by extravasated bile.

Having been able by the use of cat-gut ligatures or sutures inserted before cutting the liver tissue, to avoid these accidents, which are the only dangers met with in the liver due to anatomical peculiarities, the bloodvessels being adherent to parenchyma of organ, I have (at least on dogs and cats) proven that the liver can be handled, operated upon, and in short, treated surgically as successfully as any other organ enclosed in the serous cavities of the body.

Post-mortem examinations frequently show cicatrices in the liver; this proves that nature has cured injuries or surgical lesions of the liver in man.

The method of ligating vessels, ducts, etc., in the liver I have found by experiment to be feasible is this: Aseptic cat-gut ligature, medium size (not too fine), armed with a needle (without sharp edges, to avoid cutting vessels) at both ends of the ligature, as it must be introduced and tightened as a shoe-maker sews leather, so that all the tissues are included in the loops. Where the ligatures or sutures cross in the tissue they must be tied or be drawn tight, so as to cut through the parenchyma only. By this plan, the vessels being tough, are not cut, but drawn to the center by the ligatures. It will be found the most simple plan to first introduce all necessary sutures, leaving them all loose at first, and then tying tightly to complete the suturing. An experienced hand will feel the cat-gut cut through the parenchyma of the liver until the vessels alone are included. They are elastic,

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and can be tied snugly. But the tightening should be done carefully for to draw the sutures too tight would cut the vessels and ducts also, which would necessitate another set of guarding sutures farther back in the organ; and of course the less we cut into the liver the better for the patient. If not an experienced surgeon, I should advise the operator to try this procedure upon some animal, e. g., the dog, before operating upon the human subject.

The next move after securing the vessels and ducts is to remove the morbid tissue or neoplasm, and the knife is the cleanest, most satisfactory instrument for this purpose. Crushing leaves dead tissues, hence it is better not to crush, for as long as all vessels are secured we may use the knife with safety. Of course, in case of injury to liver, where the bleeding is the only danger, there would be no necessity of excising any of the hepatic tissue. The suturing being completed, the next step is to cover in the wound in the liver.

I have found that to cover the line of incision or stump of liver tissue, if a tumor has been removed) with a fold of omentum sewed on to the capsule of the organ with catgut, is decidedly advantageous, as we can in this way prevent the formation of undesirable adhesions that might form, if the surface of the liver were not covered in with peritoneum.

It is therefore well to cover all the exposed liver tissues with peritoneum, or so-called omentum.

This can easily be done by elevating a fold of omentum, stitching it to the capsule of the liver, just above the point where the sutures depress it, or a little farther back, say from one-half to three-fourths of an inch.

If the gall-bladder is full at the time of the operation, it is well to aspirate it (we might evacuate it with the hypodermic syringe). We may thus avoid the diarrhœa likely to be caused by an excessive secretion of bile. I found this to occur quite generally in animals for a few days (usually from one to three) after the operation.

The surgery of the liver includes excision for partial destruction, following injury, gangrene, etc.

Excision of parts in a condition of disease, whether benign or malignant, may be readily performed as long as the part removed, or needing removal, does not interfere with the vena porta or the bile ducts. To such excisions my method is especially applicable.

Of course the practice of aspiration of cysts will not be affected by this method in question. But in case one expecting to draw off fluid

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should find a solid mass the operation might be carried ahead to completion by excision, and my sutures employed.

The liver, if movable (Wander Leber), could be replaced and by cat-gut sutures fastened to surrounding peritoneum, just as the kidney has been treated in similar conditions—certainly the capsule insufficiently dense for such a procedure.

All of my experiments are made with the greatest care to avoid septic infection, the operation being made strictly aseptic as far as possible.

REPORT OF EXPERIMENTS UPON THE LIVERS OF ANIMALS, ETHER BEING USED IN ALL OPERATIONS.

Case 1. Dog, yellow, age two years, weight twelve pounds; good condition; shaved, washed the abdomen. Incision at lower border of rib, four inches in length; liver being exposed, the edge was raised out and held by an assistant, while ligatures or sutures were introduced and tied. There was removed one and one-half ounces of liver substance. I then drew up a fold of omentum to cover the wound and fastened it with cat-gut sutures, passing some of the same stitches through the upper edge of the abdominal wound to support the liver. I then closed the wound but kept the sutures in muscles of abdomen. Lastly a set of sutures were inserted and the wound dressed antiseptically; result, primary union. I did not wash out abdomen, but pressed out all the fluid I could by pressing the hands upon the ribs of the dog.

Diarrhæa on second day the only evil effect. I cut out specimen three and a half weeks later. This animal is now well and hearty.

The method described was followed in the subsequent operations, the results of which were in brief as follows. The post-mortem appearances demonstrating continually the usefulness of the operation and the perfect feasibility of its performance.

No. of Case.	Date			Weight.	Cond.	Removed	Result.		Specimens Removed in
1	Feb. 13, 1885.	Dog.	Male.	12 lbs.	Good.	℥ 1½	Primary	Union.	30 days.
2	Feb. 21, 1885.	"	"	30 "	"	℥ ii	"	"	14 "
3	Feb. 24, 1885.	"	"	10 "	"	℥ i	"	"	75 "
4	Feb. 24, 1885.	"	Female	12 "	Rut.	℥ i	"	"	14 "
5	Feb. 28, 1885.	"	Male.	25 "	Fat.	℥ ii	"	"	21 "
6	Mch. 10, 1885.	"	"	20 "	Fair	℥ ii	"	"	14 "
7	Mch. 12, 1885.	"	"	28 "	"	℥ ii	"	"	21 "
8	Apr. 1, 1885.	"	"	10 "	"	℥ ss	"	"	14 "
9	Apr. 10, 1885.	"	"	12 "	"	℥ i	"	"	21 "

Nos. 8 and 9 I removed part of gall bladder—one-fourth inch of base or sac. Results same, i. e. primary union.

—*C. C. Roehr, M. D., Milwaukee, Wis.*

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Editorial.

The Assassination of a Physician.—A few weeks since, Dr. Thomas Waugh, of Chicago, was shot in the back by a courageous man by the name of Sweet, who bravely attacked him under cover of the darkness of night, and who after the shooting quite as bravely fled. It afterwards transpired that Sweet had a grievance (?) in the form of undue intimacy between the doctor and Mrs. Sweet, who had been under his professional care. It seems that Sweet had observed the amorous amusement of the pair on three occasions, via a peep-hole, which he had bored in the wall, but he had succeeded in suppressing his righteous indignation until the evening mentioned, when he sought the destroyer of his domestic peace, and slew him in the manner aforesaid. The exact cause of this sudden explosion of wrath, is not stated, as his observations via the keyhole had been made with great complacency, but we presume the doctor had presented him with his bill, which is in itself a sufficient justification of the assassination in the eyes of the average man.

The grand jury failed to find a true bill against the assassin, basing its action it is alleged, upon a confession said to have been made by the murdered man before his death, but quite as likely upon the fact that the victim of the murder was a physician. One brilliant juror remarked that "these d—d doctors must be taught to let their female patients alone." A further remarkable circumstance, is the assertion made by persons presumably quite competent to judge, that at the time the alleged confession was made, Dr. Waugh was delirious, and incapable of making a lucid statement of any kind. Now, while an occurrence of this kind is very injurious in its reaction upon the honor of a respectable profession, and greatly to be deplored by all who are of upright minds, and who hold the honor of the profession in the high estimation it deserves, there are some features of the case which plainly illustrate the one-sidedness of public opinion, whenever and wherever a physician is involved. Had Waugh been a layman, there is little doubt that his cowardly assassin would at least have had a trial, and most probably a punishment of greater or less severity. No doubt, each juryman put himself in Sweet's place, and mentally murdered Dr. Waugh for his invasion of the sanctity of the Sweet domicile, but what would have been his course of action, had he been placed in Dr. Waugh's shoes, and had temptation thrown in his way? There is one point, which the average man fails to consider in such

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matters, viz., that it takes two to make a bargain, and that the honor of a virtuous woman is safe in the hands of even an immoral physician, who, be he ever so base, is still alive to his business interests and is not likely to endanger them by any forcible coercion of his patient's scruples. That the average physician would be so foolish and forgetful of his best interests and reputation as to make definite advances where there was the slightest possibility of a repulse, is hardly probable. This aside from any moral consideration. There is hardly a physician in general practice, but can testify that the profession of medicine is one which is attended by great temptations at the hands of persons who consider the doctor to be a man who is fair game, and whose best interests lie in the direction of discreet silence. Verily, between such persons upon the one hand, and professional blackmailers, hysterical subjects and nymphomaniacs upon the other, not to speak of a touch of that human nature, which makes all men kin, the doctor is in a worse predicament than was poor Odysseus, for he could hope to escape from both Scylla and Charybdis in a reasonable time, while your poor devil of a doctor is menaced by them throughout the whole of his professional career.

Contrary to the generally prevalent opinion, there is nothing about the majority of gynecological patients to fascinate the physician, and if the truth were known, people would appreciate the condescension of the physician in treating this class of maladies. There is little of romance in cotton tampons and Sim's speculum, nor is there much erotism in the pessary. The cases of alleged assault made by physicians have almost invariably been either cases of blackmail, or of hysterical delusion, aided by anæsthesia. Examples of injustice done under such circumstances are numerous. The case of Dr. Bradley, of England, is an example. Lord Coleridge himself maintained the injustice of the sentence, yet the doctor went to prison for a lengthened period. It must be admitted that in cases like the Waugh-Sweet affair the party of the second part must be more than half willing, for the seduction of a married woman is more poetical than practical. That the husband took the matter quite coolly is evidenced by his own testimony, and the possibility of collusion between the husband and wife is by no means chimerical. The action of the grand jury in the matter was a travesty on both law and justice. Had the husband detected his wife and her paramour in *flagrante delictu* and killed one or both, there might have been some excuse for the jury's action, but

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emotional insanity does not fit nicely, the man who does the peep-hole act three successive times, and then steals upon his victim in the darkness and shoots him in the back; at least, we trust that the case may not go upon record as such. Perhaps Dr. Waugh received his just deserts, but that Sweet received his is more than doubtful, and that Mrs. Sweet did not receive hers, is certain. Perhaps if the juryman's proposition were reversed, and a little were done in the way of moral training of the female patients who seem to him in such great danger, the proper measure of correction in such cases would be applied. It is a little worthy of remark that the man whose righteous indignation could become sufficiently appeased to forgive his wife, who had really done him the greater injury, should have found it necessary to slay the doctor. Exactly how the equilibrium of his mind was maintained, with such a peculiar admixture of callosity and sensitiveness, is difficult to conjecture. We are in no sense attempting to condone Dr. Waugh's offense, if such be proven, but we do protest against such a pronounced display of bitter one-sidedness as has been shown by the jury.

Scandals involving the profession are few and far between, even when compared with the clergy, who are vastly in the minority in point of numbers, and there was really no crying need of a terrible example for the edification and protection of the public. There is one thing which is devoutly to be wished, and that is a radical change in the management of cases of gynic disease. Either the whole field of gynecology should be relegated to female practitioners, or the physician should refuse to treat such cases except in the presence of a lady assistant. Then the doctor, perhaps, might be like Cæsar's ideal wife, "above suspicion," for be he "as chaste as ice, and pure as snow, he will not escape calumny," as the matter now stands. For the professional roue, who uses his profession as a lever wherewith to take advantage of the innocent and unwary, there is no punishment too severe; but in the face of the extreme rarity of such cases, justice should be a trifle less poetical and a deal more practical than in the illustrations we have recounted. The strict letter of the ancient law was "thou shalt not kill;" but as interpreted by the intelligent (?) and incorruptible (sic) juries of modern times it will probably read, "thou shalt not kill any one but doctors." This may be a satisfactory answer to "what shall we do with our graduates?" but it can hardly be impartial justice.

G. F. L.

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Medicine.

Edited by WM. E. QUINE, M.D., 3151 Wabash Ave.

Vital Statistics of the United States.—In several of the censuses of the United States an attempt has been made to secure information in regard to the various subjects included under the general term of vital statistics, with but hitherto only a modicum of success. There is now lying upon the table before us the report of Dr. John S. Billings, U. S. A., on the mortality and vital statistics of the United States as returned at the tenth census, of 1880; and owing, no doubt, chiefly to the labor and wisdom of Dr. Billings, this report seems to give information at once important and reliable. The number of deaths, with information in regard to their causes, during the year 1880 was obtained as far as might be by the official enumerators. There was also sent out a register to every physician in the United States whose address could be secured, with the request that the registry should be filled out by him from the records of his practice during the year. Of these physicians' registers there were distributed, omitting odd numbers, 76,000, and returned about 26,000. The total number of deaths reported in them was 166,896, of which 61,020 were found not to have been reported by the enumerators. The total number of deaths reported by enumerators and physicians for the year 1880 is 756,892, giving a death-rate of 15.09 per thousand. In an elaborate discussion, Dr. Billings shows that this death-rate is somewhat too small, making it very apparent that the mortality rate in the United States during

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1880, a fairly average year, was very close to 18 per thousand of living population. A comparison of this rate with that of other countries shows that it is less than that of any other civilized country, and very much less than that of the majority of European states. Thus, the death-rate in Austria is 29.6 per thousand; in Italy, 30.5 per thousand. When, however, it is remembered that our population is largely made up by persons who have immigrated to this country at ages which have the lowest death-rate, it would appear that our annual mortality rate is too high; and we are in accord with Dr. Billings in believing that there is an annual unnecessary and preventable mor tality of 100,000.

Dr. Billings discusses the several factors or circumstances to be considered in studying death rates under twelve heads. Much of interest to the general profession is to be found in each of these sections, but we shall confine our comments to the question of race. It is, in the first place, very clear that the mortality among the colored people, is excessive, being about 2½ per thousand more than that of the white race. It is not clear, however, that this is due to racial characteristics. The almost universal poverty, the improvidence and ignorance of the blacks may be the real causes. Especially is this probable, since the main cause of the excess of mortality in the colored race over the white is found in the enormous number of deaths occurring in children under five years of age.

The statistics in regard to the Indians are of necessity very imperfect; 1,859 deaths are reported as occurring in a population of 78,521 Indians, giving a death rate of 23.06 per thousand. A fact which would hardly have been anticipated is that the proportion of deaths from consumption among the Indians compared wtth the whites is 286 to 166. The total absence of morality among the Indians, and the general promiscuous sexual intercourse between their women and the lowest grades of whites on the frontier, prepare us to recognize as fairly accurate the statement that venereal diseases kill of this race seventeen times as many as of the whites, but we did not expect that pregnancy should result in twice the proportion of deaths, as the ease with which Indian women bear children is notorious, and we had supposed atoned for the absence of the skilled accoucheur.

Is Tuberculosis Transferable by Vaccination?—The principal objection urged against vaccination from the part of those opposed to this procedure is the alleged danger of transferring a specific taint, such as

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syphilis or tuberculosis. The question of the contagiousness of tuberculosis being at present a favorable topic with the profession, it seems quite apropos to inquire into the chances of propagating the tubercular taint by vaccination. Looking over the literature of the subject, we find that the *Gaz. Hebdomad. de Med. et de Chir.*, 9, 1885, has gathered the most important pertinent material.

Toussaint presented in 1881 the results of his work on this subject to the *Academie des Sciences*, and created no small antipathy, though scarcely justifiable, against vaccination. He took some virus from a healthy and, as to any specific taint, wholly unsuspected child and vaccinated with it successfully a notoriously tubercular cow. From this cow Toussaint vaccinated four rabbits and one pig, rendering the latter and two rabbits highly tubercular. This observation is, in the first place, the only one of its kind, and the animals experimented upon are anything but eligible for the purpose, Dr. Formad's researches having elucidated the fact that the rabbit is *per se* a tubercular animal. Vulpian, indeed, protested immediately at the time against drawing any definite conclusions from the experiments of Toussaint.

In 1882, Lothar Meyer published his "vindication of Jenner's humanized lymph" in *Eulenburg's Viertelj. f. Ger. Med.*, in which, proceding from a theoretical ground, this author denied, *a priori*, the possibility of transferring tuberculosis by vaccination. He re-vaccinated eleven phthisical individuals in the advanced stages of the disease, and found no tubercle-bacilli in the examined pustules. Straus repeated in 1884 the experiments of Meyer with absolutely negative results. Josseraud (*These Inaugurale*, Lyons, 1884) instituted under Prof. Chauveau's direction, similar experiments; he examined the pustules of fourteen vaccinated phthisical persons without finding a single tubercle-bacillus. The lymph taken from these pustules and injected into the connective tissue and peritoneum of a guinea-pig gave likewise a negative result. Reviewing the stated experiments, it appears highly improbable that any tubercular propagation through vaccination is likely to occur. Chauveau and Bollinger hold besides that tuberculosis cannot be transmitted by a superficial skin-lesion.

The control-experiments of Dr. F. Schmidt fully coincide with the results obtained by other observers. Six series of three healthy guinea-pigs were vaccinated with the same tubercle-matter, one

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always subcutaneously or into the peritoneum, the two others on various epidermal erosions. Without exception the animal of each series vaccinated according to the ordinary method in different places remained healthy, the others grew tubercular.

Finally, if we consider that since the days of Jenner millions of people have been vaccinated and that the literature has not recorded a single authentic case of vaccinal tuberculosis, beginning with a local tubercle, then proceding to caseous degeneration of the axillary glands, etc., the danger of transmitting tuberculosis torough vaccination must evidently be regarded as imaginary.

Hysterical Paralysis and its Treatment.—In the difficulties which sometimes arise in the diagnosis of hysterical conditions, the physician must often have wished himself a second Ariel, able to watch his Miranda unperceived, upon a desert island. If the solitude were absolute, and if the stern pressure of want of food were called in, some paralyses would disappear, and some appetites would improve. We have learned of late years a great deal that enables us to classify many nervous diseases upon the basis of a visible and constant organic pathology, and we are constantly anxious to add more to the list, but some important maladies, such as epilepsy, hysteria, and megrim, steadily baffle the mycroscope; and, what is worse, hysteria sometimes baffles diagnosis. The more trouble is spent upon it, the wider seem the conditions it may include. Hysterical paralyses have been for long troublesome, needing some easy sign of recognition, in place of the long and patient watching which may often prove the only path to diagnosis, unless a rapid guess be hazarded. It was thought at one time that some faith could be prudently put in the indications of the tendon-reflexes; that, if the limb were in a hysterical contraction, it would have no increased tendon-reflex such as generally accompanies contraction due to organic disease; and, again, that if it were slack and powerless, there would not be the same great diminution of tendon-reflex that there is generally in organic paralysis, of cerebral or spinal origin, before a descending degeneration has set in. Tendon reflexes, it was considered, were out of voluntary control if properly examined, and no tricks could be played with them. But, unfortunately, even though the subject may be unwilling, it seems as if nature could play tricks with them nevertheless.

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MM. P. Marie and Souza-Leite have recently, in the *Revue de Medecine*, from an observation of cases collected at the Salpetriere, published a group of instances of paralysis which show themselves to be what we should call purely hysterical, by their rapid transference from side to side, or sudden disappearance, and yet in which the tendon-reflexes varied in all ways, sometimes following the general rules of organic paralysis, and sometimes reversing them. However, when we have sufficiently clearly established the ordinary rules of tendon-reflex in organic paralysis, if we find some cases contradicting them, we may justly suspect them to be without organic origin; but we cannot hope to detect all hysterical paralyses by such tests, as many show symptoms in this respect identical with the abnormalities due to organic disease. The first case in which M. Charcot, in 1865, established by the microscope a so-called typical instance of sclerosis of the lateral columns, was thought in life to be entirely hysterical; and, on the other hand, several cases since observed which showed symptoms not to be distinguished from the first, and were presumed to be organic after the same fashion, have been carefully shown to have, after death, no organic abnormalities. The extent to which morbid nervous symptoms may go without a pathology, should serve the useful purpose of keeping us humble in our claims to have acquired the key to all the processes of the nervous system. On the other hand, the possibility that a case which looks hysterical may possibly be organic, or partly organic, cramps treatment by the fear of mistake. To treat a monoplegia of genuine organic origin as hysterical, may look brutal or even criminal. For there can be no doubt that a strong emotion, or a strong imperative, may do away with some symptoms that seem the exact counterpart of others left untouched, but which are in reality very different from them; and herein arises one of the points of difficulty between the quack or the fanatic and the scientific physician. The first may use methods involving impossible hypotheses, or extravagant sentiment; but he succeeds in calling up the strong emotion, or in assuming, in the patient's eyes, the authority for the strong imperative; and thereby attains his ends much more triumphantly than the physician who will not simulate the emotion he does not feel, or pretend to believe what he knows to be false. There is a great force of emotion that acts in one way at Lourdes, and in another in Exeter Hall, but which may be applied in either case to the relief of discomforts that are none the less real

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because they are often misnamed. The physician, when science has made his knowledge certain, and his methods of command more varied, may hope to assume an equally effective imperative, or even to find some mental methods that involve no deception.—*The British Medical Journal*, August 22, 1885.

A "House Epidemic" of Pneumonia in Sweden.—Dr. Fr. Rudberg gives a brief account in the *Eira* of an epidemic of pneumonia occurring at the end of last year in a workman's barrack at Sandarne, near Soderhamm, in Sweden, where there are five of these barracks, situated in a row at a distance of a couple of hundred feet from one another on a piece of sandy soil near a pine wood. The epidemic was confined to one of these barracks, there only being a single case in the remaining four at the same time, and very few in the surrounding districts. This building was constructed of wood, and had sixteen rooms arranged in two stories, there being a common porch to every two rooms. Each room was occupied by a separate family. The total number of inhabitants was seventy-eight, of whom forty-seven were over fifteen years, and thirty-one under that age. The first case occurred on November 16th, in a boy of eight; subsequent cases occurred on November 27th, and December 4th, 7th, 11th, 14th, 16th, 19th, and 20th. Of these there were four males and five females, one boy and one girl being under ten, but all the rest between twenty and forty. Six cases occurred in the lower story, and three in the upper. The disease appeared to have no tendency to pass from one room to the adjoining one, or even to another room on the same story; and in no case was more than one inmate of a room affected; but one woman living at a distance, who occasionally visited some of those who had the disease, was attacked by it herself on December 14th. It should be stated that there was plenty of intercommunication among the families. The writer does not mention any of the clinical characters of the epidemic.

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Principles.

Edited by C. C. P. SILVA, M.D., 163 State St.

Physiological Action of Antipyrine.—The literature of the subject of antipyrine is immense, and in the pages of this journal during the last few months have appeared many testimonials as to the value of the drug; but any thorough scientific examination of its action upon the animal organism has not as yet been made. For the purpose of stimulating such research, by showing how little is known, we give the following *resume* of our knowledge of the action of the drug.

According to the observations of Dr. Leon Arduin (*Paris Thesis* 132, 1885), of R. Demme (*Fortschritte der Medicin*, Bd. 2, 1884, p. 657), and Dr. Coppola (*Kobert's Jahresbericht*, 1885, p. 314), it produces in frogs, when given in very large doses, complete relaxation, with loss of reflex action and death. In moderate doses (half to one centigramme) it causes opisthotonos with very marked increase of the reflexes. In the earlier stages of that condition the animal is cataleptic. According to Coppola, the convulsions are, at least in part, due to the action upon the brain, and are arrested by section of the spinal cord. Both Arduin and Demme state that death is produced by arrest of the heart in diastole; but Coppola also states that the antipyrine has no influence upon the circulation in the frog, and that in many cases after the largest dose the heart is arrested in systole.

There have been but few experiments made upon the higher animals with this drug. Demme asserts that the symptoms which it produces in rabbits are similar to those that occur in frogs. One gramme (15 grains) in his experiments produced in a rabbit very marked elevation of the blood-pressure, followed by violent tetanic cramps, progressive falling of the blood-pressure, and lessening reflex excitability. In his experiments (p. 6, 165) the heart continued to beat vigorously after the blood-pressure was reduced almost to zero, and death appears to have been produced by failure of the respiration. In the experiments reported by Arduin, three grammes (45 grains) of antipyrine produced in a rabbit cataleptic stiffness, diminished reflexes, complete paraplegia, followed by violent convulsions, epileptiform in type and occurring at a time when the reflexes were completely destroyed in the hind legs. There was also a very marked fall of the bodily temperature. M. Bouchard (quoted by Arduin) has found that the stiffness of the muscles was entirely prevented by section of the sciatic nerve, and was

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therefore of nerve origin. In Demme's experiments upon the isolated frog's heart, antipyrine rapidly slowed and enfeebled the systole, but he found that in the Williams' apparatus no influence was exerted by antipyrine upon the isolated heart, except after the most enormous doses.

The antipyrine is freely eliminated by the kidneys. Marigliano (*Kobert's Jahresbericht*, p. 313) states that it appears in the urine three hours after the ingestion, and that elimination is at its height in four, and continues for twenty-four to thirty-six hours. He states that it can readily be recognized by rendering the urine acid, and by adding a solution of "iod iod kalium," when a reddish brown color develops. Copolla affirms that antipyrine has very slight temporary influence upon the sensitive nerves, and that there is lessened sensibility at the place of its injection for several minutes. The pupils are uniformly dilated.—*Therapeutic Gazette*, October 15th, 1885.

Recent Antipyretics.—Within the last twenty years the treatment of abnormal heat of the body during disease, has received much attention from therapeutists, and we are now in possession of a group of remedies by which this heat may be reduced. At first the means chiefly employed were its direct abstraction by the contact of cold water and ice, and in many cases these will not be superseded, but in others there are reasons against this treatment, and we can then have recourse to one of the antipyretics, the list of which is now rather a long one.

In the following pages I propose to give an account of the latest additions to this list, which have occupied the attention of scientific and medical men sufficiently long, so that something definite is known as to their action on the body. On the Continent they have been largely employed in the treatment of many febrile diseases, and a short account of the results obtained cannot fail to be of interest to English medical men, who, owing to recent legislation, have not the same opportunities of testing the action of newly-invented drugs which is possessed by their brethren in other countries.

This account does not lay claim to any originality on my part, but is gleaned from the numerous papers which have appeared in recent French periodicals, reports of the meetings of scientific and medical societies, and theses presented to the Faculty of Medicine, besides observation from time to time of patients treated with these drugs in the hospitals of Paris.

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Under the head of each drug I propose to give an account of its chemical and physical nature, of what is known of its action on the healthy body, of the extent of its uses, and of the results obtained in the treatment of various diseases.

KAIRIN.

This was the first of the series of these closely related bodies. It was discovered in 1882 by Otto Fischer, of Munich, and was prepared by him from a body—quinoline. Now this body quinoline is formed as a colorless liquid when quinine, cinchonine and some other alkaloids are treated with caustic potash and subjected to distillation, and from it many derivatives have been prepared, one of which rejoices in the name of tetra-hydro-oxy-methyl-quinoline, or more simply kairin, and its therapeutic action was first made the subject of investigation by Professor Filhne, of Erlangen, who came to the conclusion that it was a valuable antipyretic.

It is a yellowish white powder, of a faint smell and bitter taste, soluble in water and alcohol, slightly in ether. Its watery solutions have a tendency to change color and become of a claret tint. With various reagents, such as nitric acid, solution of iodide of potassium, or chlorine water, it gives more or less characteristic precipitates or coloration; but the most generally useful test is that with strong nitric acid, which produces an orange red in solutions as weak as one per ten thousand, and with this reagent it can readily be found in the urine so soon as an hour after its administration, or if given hypodermically in less time. With perchloride of iron it gives a colour which is first violet and then red.

Its physiological properties have been studied by various observers in France, by MM. Hallopeau and Girat, the results of which were contained in a thesis presented to the Faculty of Medicine in 1883, and by MM. Loze and Conscience, whose conclusions are contained in another thesis presented in December, 1884; and certain facts have been well ascertained as to its action on the healthy body, which we will now proceed to relate. In the last named memoir Dr. Conscience gives the following as the effect of kairin on dogs and guinea-pigs.

Intense cyanosis of lips and tongue, with dimunition of respiratory movements, abundant salivation, rapid fall of temperature, accompanied by fits of shivering and diminution of the pulse-rate in proportion to the fall of temperature; convulsions and epileptic movements,

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and finally a comatose condition; diminution, and finally total abolition of cutaneous sensibility; paralysis and contraction of the limbs; diminution in the quantity of urea excreted.

After death the arterial blood was found to be black, the heart to be arrested in a state of diastole, with the left ventricle full of blood. The lungs, intestines, and bladder were congested, and the lines of the arteries marked with peculiar distinctness by the dark color of the blood. This peculiar action on the blood has been the subject of experiment by MM. Loze and Brouardel, (Meeting of the Societe de Biolgie, May, 1884,) in which they have found that the respiratory capacity of the blood is very considerably reduced, in some cases amounting to nearly one-half. The method of experimenting consisted in determining the amount of gases yielded by 100 volumes of blood before and after the administration of kairin, and further analysis of the gas showed that the amount of nitrogen was nearly constant, indicating that the action was on the oxygen and carbonic acid. In the course of these investigations another interesting fact was brought to light, viz. that the action of this body on the blood produced methæmoglobin—one of the products of the deoxidation of oxyhæmoglobin. According to a Russian observer the blood corpuscles undergo a change of shape which appears to be the same as that described by Dr. Roberts as produced by solutions of boracic acid, in which the central part of the corpuscle projects as a rounded prominence from one side, giving the corpuscle the appearance of a cupola.

In accordance with the diminished respiratory movements, and with the altered condition of the blood, the respiratory changes were found in the experiments of Dr. Conscience to be considerably modified and in proportion to the fall of temperature, as seen in the accompanying table taken from his thesis:—

Oxygen absorbed in 1 hour.	CO_2 produced in 1 hour.	Temperature.
Cub. metre 9·592	5·107	39·9° C.
,, 7·713	5·187	39·1
,, 4·175	1·19	36·3
,, 4·341	3·343	36·6

As regards the fall of temperature, experiments have shown that this is always produced in the administration of the drug to healthy animals, but not to any very large extent unless the doses are considerable. If a poisonous dose be given, a fall of as many as 9° Centigrade may be recorded before death takes place; but in the case of

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animals rendered febrile by the injection of septic matter, a fall of 1°·5 or 2° is quickly brought about with doses that produce no other marked effect.

Another interesting fact concerning the action of the drug on the healthy animal is, that during its administration the amount of urea excreted is considerably lessened.

We will now pass to the therapeutic side of the question; and we find that kairin has been given by numerous observers on two different plans. The first, that of Filehne, is to give the drug in small doses, varying from ten to fifty cubic centigrams, according to the general state of the patient, every two hours, making use of the thermometer before each dosage, and being guided by that instrument in its administration; the second is that of Riess, who gave large doses at a time, varying from 1.50 grm. to 3 grms. when he found that a lowering of two or three degrees Centigrade took place which lasted about five or six hours, but in one case of typhoid he reduced the temperature to 35°·8 and the patient into a state of collapse, which however passed off.

The drug has been given by the stomach and by hypodermic injection; the latter method is much praised by Dr. Queirolo of Bologna, who dissolves a quantity varying from ten to fifty cubic centigrams in a wineglassful of water, of which solution he uses ten to thirty cubic centimeters as an injection, and asserts that he has seen no ill results arise from this mode of administration. The ill results that have been recorded against the drug are abundant perspirations which quickly follow its administration but do not last any length of time; occasionally vomiting has been produced, and fits of shivering; on the re-ascent of the temperature a peculiar nasal pruritus and dryness of throat, and sometimes frontal headache.

We will now pass to the consideration of

ANTIPYRIN.

This body known chemically as dimethyl-oxyquinicine, was discovered by Dr. Knorr, of Erlangen, and first subjected to experiment by Professor Filehne, of Munich.

It is a crystalline powder of a very pale salmon-pink color, with a slightly bitter flavor, but is more easily taken by patients than kairin; soluble in water, alcohol, chloroform, and ether. Like kairin it gives various precipitates and colorations with different reagents, the most useful of which for general purposes to determine its presence are

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those with nitrous acid and perchloride of iron; with the former it gives a green color and with the latter a color resembling the pigment "dragon's blood," or when the solution of perchloride is strong, a port-wine color. Its physiological properties have been investigated by M. Bouchard,[1] by MM. Henocque,[2] Arduin,[3] and Huchard,[4] from whose researches it would appear that a toxic dose administered to a mammal produces a great fall of temperature, as much as 6·2 degrees Centigrade; the respiratory movements are at first quickened and then become much slowed, the heart-beats decrease in number with the fall of temperature, and after death the heart is found arrested in diastole. Tonic and clonic convulsions are produced, and a peculiar state of rigidity of the muscles, which allows a limb to retain any position in which it is placed, reminding the observer of the cataleptic condition. In an interesting experiment by Professor Bouchard it was shown that this action was due to the nervous system and not to an action of the drug on the muscles directly, for he found that if a limb was cut off from the central nervous influence by section of its nerve, it manifested none of this stiffness, which was found, however, in all other parts of the body.

No action similar to that of kairin on the blood-corpuscles and hæmoglobin has been recorded, though experiments have been made with this object in view, but it has been found to produce a diminution in the excretion of urea. Dr. Queirolo has made an observation which is of importance in attempting to explain its antipyretic action, and interesting when taken in conjunction with the clinical fact of profuse sweats caused by its administration, and that is, that it produces a dilatation of the cutaneous blood-vessels before the diminution of the temperature commences, a fact which might tempt us to seize the idea that it is this profuse sweating which causes the fall; but it must be remembered that this is no constant or necessary effect, and is not found when the doses are small.

I have tried the action of a five per cent. solution on the blood-corpuscles, but failed to find anything analogous to that described above of kairin.

On a healthy man, in non-toxic doses, antipyrin does not appear to lower the temperature, and it has been asserted to have the opposite

1 *Comptes Rendus de Soc. de Biologie, No. 43.*
2 *Gazette hebdomadaire, No. 50.*
3 *These de Paris, 1885.*
4 *Societe de Therapeutique.*

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effect. In the course of the experiments of MM. Arduin and Henocque a peculiar hæmostatic action was found, which may possibly be turned to clinical account one of these days, but the data are not yet sufficient to pronounce with any confidence on this property. They were induced to make experiments in this direction by finding that blood flowed with difficulty from the vessels of an animal under the influence of antipyrin, and when comparative experiments were instituted with ergot and perchloride of iron as to the time in which each would arrest an artificial hæmorrhage the balance was in favor of antipyrin.

We will now turn to the clinical and therapeutic actions of the drug; and first as to its mode of administration. It has been administered by the stomach, rectum, and skin. The first is probably the best way, unless any particular reason exists against its use. When given hypodermically a good deal of pain is produced, and when given by the rectum its usual effect is manifested, which differs in no way from that produced by injection into the stomach. It has been employed in large doses and in smaller doses given frequently, and there is little doubt that the latter is the better mode of administration, and less liable to produce the few disagreeable symptoms that have been recorded against this drug. Of course in considering the dose we must bear in mind what effect we wish to produce. If we are in the presence of an acute febrile disease, whose temperature curve is rapidly approaching the hyperpyretic region, it would be well to administer one large dose, but if on the other hand we are dealing with a chronic febrile disease, such as typhoid or phthisis, it is well to administer it only in small doses sufficient to produce a slight fall in the temperature, and at such a time as we know the fever is on the ascent. It may be stated that the ordinary dose is a half to two grammes, or eight to thirty grains.

As regards the disagreeable consequences that have followed its administration, there have been recorded: a roseolus rash which soon disappears, sometimes vomiting after large doses, and profuse sweating, which may according to some authors produce a state of great exhaustion; so that it can be plainly seen the drug requires to be given with consideration and judgment, but it is freer than many antipyretics from the production of nervous troubles, such as shiverings, headaches, and singing in the ears, deafness, etc.

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As far as my limited experience goes, I have seen none of these bad effects except the sweating, which is profuse but seems to have no bad effect on the patient. The drug can be found in the sweat within two hours after its administration.

The diseases in which the drug has been given form a long list, practically the same as a list of febrile diseases, and I do not propose to say much except on those where it seems to have a special value.

In typhoid fever the drug has been very largely employed, and the result arrived at may be stated to be a constant fall of temperature of a degree or more, varying with the dose. As may be imagined, it exercises no effect on the course of the malady, but is useful in combating the symptoms of fever, and it may be given in the afternoon or evening, as the temperature curve is commencing its ascent, with confidence that a fall of temperature will be produced; which fall, however, is not of long duration, lasting about six hours, unless more of the antipyrin be administered. In some observations made at the Hertford British Hospital in Paris by Dr. Mackew, he informs me that he noticed vomiting several times during its administration (but this was not necessarily due to the drug), and a rash as above described with the first doses (which were large, thirty grains); but a tolerance appeared to be established, for subsequently the rash was not produced. He further found that atropin or oxide of zinc would control the sweating if given before the antipyrin. The conclusion arrived at was, that it was of undoubted value in the treatment of this disease.

In tuberculosis and pulmonary phthisis antipyrin has been largely employed, and observers speak very highly of its action when given in small doses such as three or four grains for several days consecutively, for not only does it lower the temperature, but at the time "the patient experiences a sensation of *bien etre* quite remarkable, the dyspnœa is calmed, the sleeplessness disappears," so much so, that M. Huchard speaks of it as the specific, not of tuberculosis, but of the tuberculous fever. In these small doses it does not produce the sweating which would be in phthisis a very undesirable result. It is possible, but I am not aware of any observations on this point, that its hæmostatic action before described, may be of use in this disease. [Compare *Practitioner*, xxxiv. 321.]

In acute rheumatism the results obtained do not agree, possibly from the employment of different doses. Some authors praise it as

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having an action similar to, but quicker than, the salicylates while others deny that it is of any use at all.

THALLIN.

This body, whose chemical name is tetra-hydro-para-methyloxy-quinolin, derives its more useful appellation from the green color which its salts give with perchloride of iron. It was first used as an antipyretic by Rudolf von Jaksch, of Vienna, but it has not long been before the medical and scientific public, so that I am not aware of any observations giving its actions on the healthy body and its toxic effects; but it has been used by M. Huchard and by Professor Jaccoud in various febrile diseases of which I will give a short account.

Professor Jaccoud made it the subject of one of his tnteresting clinical lectures, in which he stated that he used the sulphate and the tartrate and gave it forty-three timcs to eleven patients suffering from typhoid, tuberculosis, pneumonia and erysipelas. The dose varied from 100 ccm. to 10 ccm., but in the case where he gave 100 cubic centigrams in divided doses of 25 ccm. every half hour he produced a fall of temperature to 32.4 and a state of collapse which required energetic measures to combat.

As to its antipyretic effect in typhoid with the doses and their result, we will take the following:

9th day of disease	75 ccm.	produced	fall of	3°·6
8 following days	50 ccm.	"	"	2°·7
18th and 19th days	45 ccm.	"	"	2°·5
20th and 21st days	30 ccm.	"	"	·8

From which it can be seen that its effect is well marked and rapidly produced, for as a rule the temperature began to fall in about two hours, and the abatement lasted about five hours. In the Professor's experience, thallin produces less perspiration than kairin and antipyrin, with a total freedom from sickness and headache.

The professor concludes "that in thallin we possess an antipyretic which in this quality surpasses all the others. None produce such effect and none act in such small doses with so little inconvenience. Thus if we use it in doses of five to ten ccm. every hour, we should maintain in all probability our patients in a state of apyrexia, but the effect on the course of the disease is nil."

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The conclusions arrived at by M. Huchard are similar to the foregoing; he noticed the general freedom of the drug from undesirable effects, but found that shivering was produced on the re-ascent of the temperature.

It has been given in cases of intermittent fever and was found to have an action on each access of fever, but not on the malady as a whole, thus offering a strong contrast to quinine.

From the foregoing account it will be seen that these bodies are really useful additions to our list of antipyretics, but we must wait for further experience to decide on the relative merits of each. In fact this whole group of drugs well merits a more extended study, so that we should be able to give a scientific classification of them, according as they act on the production or distribution of heat, and if on the production, by what means this is brought about, whether by the thermogenetic centres of the cerebro-spinal system, or more directly by diminishing the oxidising power of the blood. In the above recorded facts we see an indication of a difference of action between such closely allied bodies which further knowledge may break down, but it would appear that kairin acts on temperature by diminishing the oxygen-carrying power of the hæmoglobin, while antipyrin—according to the experiments of Queirolo—dilates the vessels of the skin.

The idea of the existence of thermogenetic centres is rapidly gaining ground, and we may see in the obvious action of these drugs on the nervous system a reason for supposing that this is one of the ways in which their effect is brought about.—*J. E. Blomfield, in The Practitioner*, Oct. 1885.

On the Treatment of Cases of Imperfect and Painful Swallowing.—The method of feeding by means of a tube passed through the nose into the stomach is well known, but, so far as I am aware, is not used in the class of cases for which it is recommended in the present paper. Since the beginning of the year, cases of tracheotomy, diphtheritic paralysis, meningitis, and a case of cerebral embolism have been treated in this way in Dr. Andrew's wards at St. Bartholomew's Hospital with satisfactory results, and Dr. Andrew has kindly allowed me to publish an abstract of some cases which occurred while I was acting as his house physician last January, February, and March. During this period there were three cases of tracheotomy. In the first case the treatment was not adopted, there being no special indi-

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cation for it; the child died of pneumonia on the eighth day after the operation. The next two cases were fed by the tube, and recovered; and it was the impression of all who watched them that if they had been fed in the ordinary way they would have died. Before describing the cases I may point out the objects which tube-feeding is intended to secure.

After the operation of tracheotomy there is often great difficulty in getting the patient to take sufficient nourishment. The pain caused by the movements of swallowing makes children refuse food which they are quite able to digest, and thus they are apt to be half-starved at a time when it is essential that they should be well nourished. They will not take more than a few spoonfuls at a time and their rest is seriously interfered with by the constant attempts to feed them which are necessary in order to keep them alive. A more serious and also a common occurrence, is that fluids pass into the larynx and so into the lungs, where they set up bronchitis and pneumonia; after each attempt to swallow the child coughs and some fluid returns through the tube showing that it has passed into the trachea. These difficulties may be avoided by means of feeding through the nose with an india-rubber catheter and a syringe. A No. 4 india-rubber catheter, well annointed with vaseline, can easily be passed through the nose of quite a small child into the stomach, and through it liquid food may be injected in sufficient quantity to render the repetition of the performance unnecessary for some hours. By this means we can insure that no food passes into the air passages, that the child receives as much as it can digest, and that the intervals between feeding are sufficiently long to allow of several hours uninterrupted sleep. We also know exactly how much the child has taken in a given time —a calculation which is very difficult in spoon feeding, where so much is unavoidably spilt and spluttered up.

This method of feeding is also applicable in cases of diphtheritic paralysis and diphtheria, in fact, in all cases in which there is danger of food passing through the larynx, or in which the pain of swallowing is so great as to interfere with the proper nourishment of the patient.

It may be thought that to thrust a catheter through the nose of a small child is a barbarous practice, and that it would cause so much struggling and exhaustion as to do more harm than good. As a matter of fact, however, there was commonly little, if any struggling

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or apparent discomfort; the children often hardly woke when the tube was passed, and fell asleep immediately after it was withdrawn; and in cases in which the children resisted the passage of the tube it was invariably found that they had more rest and were less exhausted than when constantly troubled with a spoon.

The first case in which the treatment was tried was the following:—

CASE I.—James Andrew Chapman, æt. 2¼, admitted to Mark Ward, February 18, 1885.

The child had been apparently quite well on the previous day, but in the evening its breathing became difficult, and it was brought to the surgery at 8 a. m. in a state of urgent dyspnœa, with great recession at the lower end of the sternum.

Tracheotomy was performed at once by Mr. Lewis with great relief; no membrane was seen.

The child took food well until the 22nd. It then began to take badly, and nutritive enemata were given and retained. On the 23d the child took better. On the 26th the food was noticed to come back through the tracheotomy tube. All feeding by the mouth was given up at once, and the child was fed entirely by a catheter passed through the nose. Half a pint of milk, half an egg, and two teaspoonfuls of brandy were given every six hours.

There was no difficulty in passing a No. 4 india-rubber catheter, and the sister was able to feed the child so easily that he scarcely woke, and he always fell asleep as soon as his stomach was full.

On March 10, the tracheotomy tube was removed, and the wound soon closed; but it was found on trial that liquids still passed into the trachea when he was allowed to drink. The nasal feeding was therefore continued until March 12, when he was able to eat and drink properly. He left the hospital well, but has since died of pulmonary tuberculosis.

CASE II.—Sydney Harold, æt. 15 months, admitted to Hope Ward, March 16, 1885.

The child had suffered from whooping-cough when three months old and a cough ever since. On the evening of March 15th its breathing became difficult, and it was brought to the surgery at 6 a. m. At this time both expiration and inspiration were impeded. There was considerable recession above the clavicles and at the lower part of the chest, and diphtheritic membrane was seen on the tonsils. Two

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other children in the same house were ill at the time with sore throats. At 11 a. m., as the child would not drink, it was fed through the nose with milk.

At 1 p. m. recession had become greater and the lips more blue. Tracheotomy was performed by Mr. Lewis; a small piece of membrane was coughed up. After the operation the child did not take at all well, and was fed every four hours with the tube, and this method of feeding was continued until April 3. During this time there was some inflammation around the wound, and the bowels acted four to six times a day. Vomiting occurred twice only. The child took small quantities occasionally by the mouth, but so little that without the tube it must have starved.

On March 29, the tracheotomy tube was removed, and on the same day signs of consolidation at the base of the left lung were observed.

On April 3, the wound was nearly closed, and the child for the first time took sufficient food naturally. The signs at the left base gradually cleared up, and the child went on well without nasal feeding until April 12, when signs of pneumonia of the right upper lobe were observed. This attack ran a typical course. The temperature varied between 103° and 104°. 2, falling to normal on the eighth day.

When the attack began this child refused its food, and tube feeding was again resorted to and continued until the 19th, when the crisis occurred, and the child began to take naturally. After this the tube was only used occasionally, and at night. The child made a steady recovery, and was sent into the country on May 6.

During the last attack of pneumonia there was a little vomiting but never of the whole quantity injected.

This child was fed almost entirely by the sister and nurses of the ward and they experienced no difficulty, it soon became used to the tube and did not seem distressed by it. A few weeks ago the mother called at the hospital and the child was then alive and doing well.[1]

Case III.—Paralysis after Diphtheria.—William Curzon, æt. 4, admitted to Mark Ward, March 16, 1885.

The child had a sore throat early in February and on the 24th its mother noticed that it had difficulty in swallowing, On admission there was slight facial paralysis on the right side. Fluids returned through the nose and the child choked when it attempted to swallow.

[1] Since the above was written the child has been brought to the hospital; it continues well.

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Moist sounds were heard all over the chest, and the fauces and larynx were much clogged by mucus. Frequent cough and impaired resonance on right side of chest. There was no inflammation of the throat. The child was fed entirely by the tube, the mucus in the air passages diminished and the chest signs improved. On March 26, the child was able to drink without choking and the tube feeding was given up. He was discharged well on April 18.

In this case it is very probable that the bronchitis was set up by the food which passed down the trachea before the child came to the hospital, and that if the ordinary mode of feeding had been continued the child would have died.

In this case the child objected strongly to being fed, struggled a great deal, and succeeded more than once in coughing up the end of the catheter as it was passing through the pharynx. A very fine stilet was therefore passed down the catheter to within about an inch of the end and it could then be easily passed.

The same method of treatment was adopted in a case of diphtheria in a child aged one year and eight months, and in several cases of meningitis in which the patients were unable to swallow. These cases ended fatally, but the patients survived long enough to show that tube feeding may be persisted in for a considerable time without bad effects and that no accident is likely to occur.

The last case I shall mention is that of Catherine M'Carthy aged twenty-eight, admitted to Hope Ward, February 14, 1885, having suddenly lost her consciousness on that day. She was the subject of mitral and and aortic disease, and her attack was due to embolism of the right middle cerebral artery.

She had left hemiplegia and complete inability to speak or swallow. She was fed by the tube, introduced sometimes through the nose and sometimes through the mouth until the day of her death on the 20th of July. During this long period no accident happened.

I trust that the above cases are sufficient to prove that tube feeding is a perfectly safe and not inhumane process, and that the disadvantages attending it are far outweighed by the good it does.

With a tube we can place the food in the stomach with certainty, but with a spoon it is impossible not to divide it between the stomach, the lungs, and the bed. The tube allows sufficient intervals of sleep on a full stomach, but the spoon often causes wakefulness on an empty one.—*J. F. Bullar, M.B. Cantab. F.R.C.S. Eng.*

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Dermatology.

Edited by HENRY J. REYNOLDS, M.D., 2200 Michigan Ave.

AMERICAN DERMATOLOGICAL ASSOCIATION.

[Concluded from page 432.]

Dr. W. A. Hardaway believed that in psoriasis we have a disease situated in the skin itself. It is frequently hereditary. The same sort of skin may be transmitted just as a certain color of the hair or of eye may be transmitted, and then any exciting cause may develop the psoriasis. Traumatism is frequently the exciting cause. He had seen psoriasis follow eczema. It is not unlikely that in seborrhœa of the scalp there may be the development of psoriasis. Internal causes may produce it. He had seen the excessive use of oat-meal produce typical psoriasis.

In the treatment of psoriasis it is important to regulate the diet and aid digestion in all possible ways. As a local application, he considered that chrysarobin, with salicylic acid, was very useful in chronic cases. Arsenic is useful on account of its action on the skin. This treatment may be followed up by the application of sulphur ointment. In psoriasis of the scalp sulphur is quite an efficient remedy.

Dr. Greenough said he had not intended to cover the entire ground of psoriasis in his paper. The omission of a consideration of seborrhœa was an oversight. In regard to pigmentation, he referred especially to those cases of psoriasis of the trunk, which were most apt to be confounded with syphilides.

Dr. J. C. White, of Boston, then reported some

CASES OF ANGIOMA PIGMENTOSUM ET ATROPHICUM.

Two cases were reported. The first patient was a young man seventeen years of age and a Russian Pole by birth. Freckles appeared on his face before he was two years of age. These increased in number until the age of six. When the telengiectasic condition first appeared is not noted. When seen, the patient was well developed and apparently in good health. He has, however, grown slowly, and is now no larger than a boy of twelve. The hair of the head is abundant and intensely black. The eyes are also black.

Present Condition.—Melanosis. The forehead and lower portion of the face are of a dark-brown color, and on close inspection small spots of a darker color are seen. The whole trunk is as dark as the skin of a dark Spaniard. The scrotum is very black, and the penis and glans

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present dark spots. The arms and hands are thickly spattered. The legs are also affected. On the right thigh there is one spot of dark color, covered with rather long hair. The mucous membrane of the mouth and pharynx is free from melanosis.

The Atrophic Condition.—On the right side of the face occupying one-half the surface, is a sharply defined area of white cicatricial looking skin. Similar areas are seen on the other cheek, forehead and about the mouth. A few white spots are seen on other portions of the body. The sensibility of the affected areas is decidedly lessened.

Telengiectasis.—Over parts of the face, there are bright red spots, varying in size from a pin's head to a pea. They are most noticeable in the atrophied portions. Within the lids, there are two angiomatous new growths. Several vascular twigs are also seen on the face. A few red points are found on the general surface.

The second case is a brother of case 1, aged three years, born in New York. When eighteen months old, little colored freckles were noticed on the face. Since then the condition has been developing. His hair is dark-brown and eyes are black. The face is covered with numerous dark-brown freckles. The spots are so close together that at a little distance, the skin has a uniform color. In some places, the spots are slightly elevated. The backs of the hands are covered with dark-brown spots; elsewhere the skin is clear. There are no leucodermic spots and no angiomatous condition.

From a study of these cases he concluded that in the beginning, the development of these spots can not be distinguished from ordinary freckles. Gradually they multiply until they involve a considerable portion of the skin. It is probable, that several years may advance without other manifestation of the disease. The telengiectasic condition is probably secondary. In the first case it is most developed in the atrophic portion. It is probable that in this case, there will be hypertrophy of the epithelium and final transformation into epithelioma. This has been the result in the thirty-three cases which have been reported.

Dr. Taylor thought that there was a direct relation between the red spots and the macules. The history of the cases which he had seen, had been first a rash, then the red spots, and then the macules. In one case, the teleniectasis followed exposure to heat.

Dr. White recognized a great difference in this disease as described by various writers, but he insisted on the correctness of his own ob-

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servation. The younger child had exhibited none of the precedent hyperæmia which has been noted in some cases. The patient has been observed after exertion and when exposed to intense heat, but there has been no hyperæmia. The same is true of the first case as far as known. In the second case which is still developing, there is no enlargement of the vessels.

Dr. J. Nevins Hyde, of Chicago, read a paper on

THE RELATIONS OF LUPUS VULGARIS TO TUBERCULOSIS.

He began with a detailed statement of all the cases of lupus reported to the Statistical Committee of the American Dermatological Association during the last seven years, and compared the frequency of the disease in this country with that reported in the Vienna Hospitals. He then gave details of twenty consecutive cases observed by him in Chicago. The clinical deductions from these records were then added, showing, according to the author, that there was a remarkable absence of pulmonary tuberculosis, scrofula and allied diseases in the family histories of the last twenty cases reported.

The teachings of the two schools, represented in the past by prominent German and French authors, were then referred to, and finally the latter investigations demonstrating that lupus vulgaris was the result of bacillus infection, not to be differentiated in external appearance of the parasite from the bacillus tuberculosis.

The following clinical facts were then cited in support of the later teaching of this subject as bearing on the vital point in the author's argument, viz., that lupus vulgaris was not the result as had long been taught of tuberculosis or other systemic diathesis, but was the product of a local infection by bacilli, entirely unassociated with any constitutional evidence of diathesis or predisposition. 1. The unimpeachable character of the family record in by far the larger number of cases of lupus vulgaris. 2. The fact that the disease is in its inception a disorder of the period of childhood, when for the most part, the habits of the child are favorable to infection. 3. The several sites of predilection are those most favorable to such infection. 4. The failure of the disease to spread by inheritance. 5. The remarkable tendency of lupus vulgaris to cutaneous limitation.

Dr. J. C. White, of Boston, read a paper on

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THE TREATMENT OF LUPUS BY PARASITICIDES.

He briefly interviewed the evidence in favor of the parasitic nature of the affection. All previous plans of treatment which had proved most successful, were those which would have the effect of destroying any parasite which might be present.

A number of cases were then reported in which the local use of corrosive sublimate in the strength of two grains to the ounce of water or unguent had been used with beneficial results. The ointment was especially recommended. It had been rarely necessary to prolong treatment over two months. As regards the permanency of the cure, the author was unable to speak, as the experiments had been continued for only eighteen months.

Dr. S. Sherwell, of Brooklyn, expressed his profound disbelief in the parasitic nature of the disease, and did not think that theories of Koch had been entirely proved. It seemed to him that lupus and the scrofulous diathesis represent some form of syphilitic heriditary influence.

Dr. S. Wigglesworth, of Boston, suggested that the oleates might be more efficient than ointments, on account of their penetrating power.

Dr. Hyde said that at the last meeting of the Association, Dr. Taylor suggested the use of a solution of corrosive sublimate in tincture of benzoin. He had used this in cases of lupus and in cases of infecting chancre. It makes an excellent application.

Dr. W. A. Hardaway then read a paper on

THE TREATMENT OF PORT-WINE MARKS BY ELECTROLYSIS.

In the treatment of this affection, the object is to excite sufficient inflammation to cause occlusion of the vessels. Electrolysis seems to be the most convenient way of doing this. At first the speaker had used a bundle of needles, but he now employed only the single needle. It is important to allow a period of some weeks to elapse between the applications. The histories of three cases were given in which this method had been employed.

Dr. J. C. White had used this method in one case, and had obtained considerable improvement.

Dr. Fox thought that all admitted that spider cancers and telengiectasis are amenable to treatment of different kinds, but when we come to port wine marks, a difference is found. Better results can be obtained by electrolysis than by other measures, but it does not remove the

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trouble entirely. He had sometimes passed the electrolytic needle deeply, endeavored to strike the artery of supply, and sometimes had produced a decided effect.

Dr. Denslow recently had seen a case of port wine mark on the labia majora of an infant. This had ulcerated when the child was brought to him. As a temporary measure, he applied the liquor gutta-percha. In two days, without other treatment, the whole mark sloughed out, leaving nothing but a simple ulcer, which completely healed in the course of three weeks.

Dr. Hardaway said that the advantage of the electrolysis is that it is manageable. A practical point might be referred to, and that is, if after the operation the part be frequently mopped with hot water, the inflammatory disturbance will be greatly lessened.

Dr. S. Sherwell, of Brooklyn, then read some

REMARKS ON A MOOT POINT IN THE ETIOLOGY OF PSORIASIS.

He said that he had been struck by the great diversity of opinion in regard to the general health of those affected with psoriasis, and in order to arrive at something like a consensus of opinion on the subject, he had referred to the writings of most of the authorities in dermatological matters. Brief extracts from various writers were then given. The evidence thus obtained, strengthened the Doctor's opinion that the patients with psoriasis were generally in good health. He thought the theory of Piffard, who believes that the rheumatic diathesis is a great exciting cause of psoriasis, was the most rational theory that had been advanced.

THURSDAY, AUGUST 27—SECOND DAY.

At the business meeting the following were elected

OFFICERS FOR THE ENSUING YEAR:

President—Dr. E. Wigglesworth, of Boston, Mass.

Vice-Pesidents—Dr. I. E. Atkinson, of Baltimore, Md., and Dr. A. R. Robinson, of New York, N. Y.

Secretary—Dr. G. H. Tilden, of Boston, Mass.

Treasurer—Dr. H. W. Stelwagon, of Philadelphia, Pa.

Dr. E. B. Bronson, of New York, was elected to membership.

The next meeting will be held at Indian Harbor Hotel, Greenwich, Ct., the last Wednesday of August, 1886.

Dr. G. H. Fox briefly described

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TWO CASES OF DYSODROSIS.

The first patient, for want of a better term, he classed under this heading. The patient was twenty-nine years of age, and had always perspired freely. Four years ago the eruption began on the palms of the hand and had persisted. The soles of the feet had also been affected at one time. The skin of the hands was decidedly thick and had a dark hue, and was dotted with numerous elevations of epidermis, averaging in size that of a hemp seed. The patient had never seen any moisture in connection with this. There had been no itching. The skin never peeled off. Puncture with a needle revealed no serum or fluid of any kind.

The second case was that of a woman aged 45, a cook, whose general health was good. The present trouble began five years ago. The eruption is on the face, and consists of numerous large and small vesicles containing clear fluid.

Dr. Tilden thought there was a good deal of resemblance between this case and the cases of perforating ulcer of the foot, and this would lead to suspect a nervous element.

Dr. Morrison had been led to consider it a strictly local affection, from the fact that the hand which was most exposed to rubbing and to the heat of the furnace, was the one most affected.

Dr. Duhring would be inclined to consider the callosities a secondary condition. The occupation probably had something to do with the aggravation of the disease, but if the occupation had been different there would probably have been a similar change. He would regard it as dependent on some deep change in connection with the nerves similar to that which occurs in perforating ulcer of the foot.

Dr. Morrison thought that as an affection of the nerve in the first place, he could hardly admit. It may be that the continued congestion of the skin, dependent on his occupation, produced changes in the nerves or other part, which culminated in this affection. In referring to the literature of the subject, he had found similar cases attributed to mechanical irritation.

EVENING SESSION.

Dr. S. A. Duhring read a paper on

THE RELATION OF HERPES GESTATIONIS AND CERTAIN OTHER FORMS OF DISEASE TO DERMATITIS HERPETIFORMIS.

Attention was briefly directed to the previous articles of the reader on dermatitis herpetiformis, and to a paper showing its identity with

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the impertigo herpetiformis of Hebra; also to a preliminary note on the relation of this disease to herpes gestationis and other similar forms of cutaneous disease, read before the Association at the last meeting.

The object of the present communication was to prove the identity of so-called herpes gestationis with the visicular variety of dermatitis herpetiformis, and to show that the term herpes gestationis was a misnomer, the affection being found in men as well as in women. Secondly, that certain other so-called forms of herpes, such as "herpes pemphigoide," "herpes vegetans," "herpes pyæmicus," etc., as well as certain cases regarded by the reporters as "peculiar forms of pemphigus," must be viewed as examples of this disease; and finally, that instances of the same affection were also met with in literature under the title of hydroa, and under divers other captions. Numerous cases from English, French and German literature were cited. The paper of Dr. Duhring was stated to be looked upon as supplementary to the preliminary note referred to, and embodied the results of considerable research into literature. If the views put forth proved to be correct, a great deal had been gained for dermatology in bringing these peculiar forms of disease together.

Dr. J. C. White considered the term dermatitis herpetiformis a misnomer. The disease should be called dermatitis multiformis. The herpetic element is often wanting.

Dr. A. R. Robinson agreed with Dr. White that the term dermatitis herpetiformis is too restricted, but he would prefer some term which does not indicate the pathology, until the disease is better understood.

Dr. J. Nevins Hyde thought the term dermatitis herpetiformis is preferable, if for no other reason, because it is suggestive.

Dr. G. H. Fox showed here a photograph of a case of erythema multiformis, which might be mistaken for dermatitis herpetiformis. This disease should be placed in strong contrast with dermatitis herpetiformis.

Dr. Duhring said the name dermatitis herpetiformis was adopted because it seemed the least objectionable. The herpetiform character of the disease was characteristic. The term dermatitis multiformis is already employed to designate a form of skin trouble.

To be Continued.

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Obstetrics and Gynecology.

Edited by E. P. MURDOCK, M.D., 179 South Sangamon St.

Questions Relating to Still-Births.*—H. D. Chapin, A.M., M.D., says that there is no doubt of the fact of a tremendous loss of fœtal life, and that frequently of a quality undesirable to be wasted. As a high state of civilization seems to exhaust women physically in order to advance them mentally, it is not strange that the more cultured women, who have the means and leisure to correctly train children, are just the ones who cannot or will not have them.

The poorer classes, however, crowded in tenement houses, and unable to bring up children in a healthy condition, either morally or physically, are inordinately prolific.

It is said that in France the government is becoming seriously alarmed over the decrease in native births, and has offered inducements in the shape of a prize for the seventh child. A still-birth may be defined as the delivery of a dead child in premature labor or at full term. Death may have taken place before, or in consequence of some delay or accident during delivery. Premature labor refers to that occurring after viability and before full term. The following concise definition of viability is found in Abbott's Law Dictionary: "An infant newly born is said to be viable if the organs are in such a state of regular conformation and development as to render the infant capable of living. But if an infant, newly born, be afflicted with such a disease or malformation as to render a continuance of life impossible, the infant is said to be non-viable, and, according to some systems of law, is, so far as regards the transmission of right to legal representatives, as if he had never been born." Although there is a direct continuity in the life of the fœtus from conception to delivery at full term, a physiological difference exists between a viable and non-viable child. In the former case, not only the viscera have a more perfect development, but the hold upon uterine life is much stronger. A majority of the cases in which the fœtus is passed earlier than full term, happen before the period of viability. A miscarriage, by which is meant the expulsion of an ovum, or a non-viable child, is a much more frequent accident than a premature labor. The embryo possesses inherent vitality from the very beginning of conception, but it is not until after viability that

*Read before the New York Medico-Legal Society.

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this life can exist in any way independent of intra-uterine environment. A six-months fœtus may breathe feebly after birth, but it will usually die in the course of a short time. There are cases on record, however, in which infants have been born viable at an earlier period than is usually conceded by obstetrical authors. Wharton and Stille cite a number of cases. In one instance, a living child was born on the one hundred and seventy-ninth day, and lived four months, when it died of an epidemic disease (*Lancet*, April, 1852). Dr. Barker, of Dumfries, reported a child born on the one hundred and fifty-eighth day of gestation; it weighed one pound and measured eleven inches; three and a half years afterward it was living and weighed twenty-nine and one-half pounds (*Medical Times*, September and October, 1850).

The question of viability is an interesting one, as affording a distinction between miscarriage and premature labor, resulting in still-birth.

The vital statistics of the New York City Board of Health between the years 1870 and 1885, show 25,639, still-births and 370,757 live births—a proportion of 1 to 10.44, which is an enormously high percentage of still-births. The immense number of miscarriages that are concealed would more than offset the live births not reported. The following is the month of utero-gestation in which the cases occurred.

1	2	3	4	5	6	7	8	9	10	Not stated.
13	76	497	1,132	2,023	4,052	4,877	5,314	16,902	174	581

It is seen by glancing at this table that a large number of still-births are reported, but comparatively few miscarriages. It is not to be supposed from this that still-births are more frequent than miscarriages. The natural explanation given by the Board of Health is that in the latter cases the fœtus is so small that it can be easily destroyed and disposed of, particularly in cases of criminal abortion and illegitimate parentge. On the contrary, it is much harder to get rid of a large and well-developed fœtus, without a regular still-birth certificate and burial permit.

The following are some of the principal causes assigned by the Board of Health, selected and arranged according to their numerical frequency, from reports as far as they have been received. Difficult or protracted labor (uræmia, convulsions, remittent fever, phthisis, malarious diseases, liver diseases, anæmia, esthenia, etc.); fnnis de-

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rangements; placental diseases (fatty degeneration, etc.); asphyxia, hemorrhage (flooding); malformation of child (hydrocephalus, spina bifida, etc.); uterine diseases (cancer, metritis, etc.); atelectasis, constitutional disease of parents (syphilis, scrofula, etc.).

A large proportion of still-births occurring in New York City take place in tenement houses, in the practice of ignorant midwives. Such accidents occur, not only from a lack of proper anatomical and physiological knowledge on their part, but from the too general employment of ergot of rye to hasten labor. Every old woman who goes out to attend a confinement is supplied with her bottle of ergot, which she is not afraid to use. Indeed, some midwives enjoy quite a reputation in tenement house circles, as possessing medicines that will hasten the pains and get a woman out of her suffering quickly, although it may be at the expense of a badly torn perineum and a still-born child.

Successful Case of Cæsarean Section after Death of Mother.— Dr. J. Mark Hays, of Oxford N. C., reports a case of Cæsarean section and removal of a living male child from a woman after death by apoplexy. He found the woman comatose, stertorous breathing, left side paralyzed, both pupils widely dilated and totally insensible to light. Hypodermic injections of whisky and other restoratives elicited no response, and as death was imminent the friends were informed that she could live but a few minutes, but that there was a chance of saving her child, which was near full term.

Accordingly all preparations were made, and after all evidences of life had disappeared, the room was cleared, and he proceeded without delay with the operation. With one stroke of the scalpel he incised the skin and subcutaneous tissue from the umbilicus to the pubis; two more incisions through the linea alba and peritoneum exposed the uterus to full view. He next made an incision as low down as possible, of sufficient size to admit two fingers, liberating the liquor amnii. Using the fingers as a director he slit up the uterus to the placenta. The body of the child was now fully exposed, which he quickly lifted from the uterus. The cord was cut and tied in the usual way, and the operation was complete. The child has been fed on cow's milk and stands a fair chance of being raised.

The case is quite remarkable, from the fact that the doctor waited until life was extinct in the mother before beginning the operation, when circulation must have ceased in the cord, when experience goes

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to show that such delay is unnecessary and usually fatal to the child. [We see no reason why the operation should not be performed in time to make sure of life to the child.—Ed.]

To Err is Human.—Young Doctor: "Indeed, madam, I know all about it. I saw just what ailed this woman as soon as I came into the room. There is a young man up street who is sick with the same trouble, and I am attending him. Give the medicine as directed and I will call around in the morning."

Not long after the young man departed the pains returned, and a a messenger was sent for the old doctor, who, it was found, had just returned from a far-out call, and he gave the necessary attention to the case.

The young doctor returned next morning and congratulated himself on the happy appearance of his patient, saying: "You see I never make any mistakes." Whereupon the nurse turned down the coverings, and showed him the little one lying in the mother's arms, and asked quizzically: "Doctor, how is the young man up street this morning?"

Laryngology.

Edited by GEO. F. HAWLEY, M.D., 125 State St.

Case of Suppurative Disease of the Antrum of Highmore, with Dislocation of Cartilaginous Septum, of Twelve Years' Standing.—Dr. D. M., of Ontario, Canada, consulted me in November, 1879, and gave the following history: In 1865 had pain in his second left superior molar tooth, and an unsuccessful attempt was made to have it extracted. This probably resulted in rupturing the vessels of the dental pulp, as the doctor says the tooth was started from its socket and then pushed back again. Some time after, from intense pain and swelling of the face, a second attempt was made to extract the tooth. This was not entirely successful, as a root was left in the jaw. From this time the discharge began, and continued until I saw him, more than twelve years after.

He presented the following conditions: First and second molars gone from the left superior jaw. Above the alveolus, at the position of second molar, was a fistulous opening, made by a trephine some years ago into the antrum: in this opening he wore a hard rubber

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drain-tube, but as it was small in caliber, and too high up in order to drain the discharge from the antrum, it was of very little use. It also excited granulations in the cavity. A gelatinous polypus was found in the left nostril, growing from the middle turbinated bone. This hung by a pedicle over an opening made by necrosis of the inferior turbinated bone and the nasal wall of the antrum. From the blowing of the left nostril by closing the right with the thumb, to free it from the constant discharge, the lower end of the cartilaginous septum was dislocated and turned into the left nostril, preventing respiration, except when forced. In the pharynx, a muco-purulent track was to be seen on the left of the vertebral ridge, caused by the discharge passing down from the posterior nares. This caused a good deal of expectoration. This trouble continuing for so long a time, had somewhat affected his general health.

On the doctor's first visit in November, 1879, I only removed the polypus, as it was necessary for him to return immediately home to meet some professional engagement.

In April, 1880, he returned, and under an anæsthetic, I made first an operation on the dislocated nasal septun. An incision being made through the soft parts down to the end of the cartilage, I denuded and pushed back the soft parts, then amputated the protruding cartilage of the septum. The soft parts being brought together and held by small silk sutures, this healed by first intention, and in a week's time it would be difficult to tell where the incision had been made. The next part of the operation was the trephining through the alveolar process at the position of the first molar, directly into the bottom of the antrum, by means of a large bone-cutting drill driven by the surgical engine. This opening gave exit to discharge pent up in the cavity of the antrum. The last part of this operation was the removal, by means of the revolving bone-cutters, of the necrosed turbinated bone and the naso-antrum wall, through the anterior nares. This made an opening from the nose into the antrum extending from the floor of the inferior meatus to the middle turbinated bone, and anteroposteriorly about an inch. Through these openings the antrum was freely washed out with thymolized water, and medication applied, which consisted in blowing into the antrum the Iodoform Camphor Co. powder by means of the insufflator. There were present at this operation Drs. Farnham, Carry, Warden and Bucklin, of New York, Marvin, of Brooklyn, and Braden, of Michigan.

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I pass round wax models showing the case before and after the operation. The doctor also kindly presents himself for your examination. You will see that the respiration through the occluded nostril is quite free. The opening from the mouth into the antrum is now closing up. A permanent opening will remain in the naso-antrum wall, where the necrosis was removed. The purulent discharge has ceased, and he is in robust health.—*D. H. Goodwillie, M. D., in Can. Med. and Surg. Jour.*

TREATMENT OF CATARRH.—Dr. Henning says: I have treated hundreds of cases of nasal catarrh in all its various forms and stages, and have tried all kinds of remedies and instruments, and after close observation, have settled upon the following course of treatment:

℞ Arsenici iodidi.....gr. viij
Aquæ dest.....℥ j

M.—Sig. Take a teaspoonful three times a day. Continue the remedy for months, in either the acute or chronic form.

Also—

℞ Potas permanganus.....gr. iv
Aquæ dest.....℥ iv

M.—Sig, Pour a small quantity in the palm on the hand and snuff up each nostril sufficiently hard so that the solution will run through the nostrils and reach the pharynx. Repeat night and morning.

This treatment cures a large majority of cases speedily and permanently. I have abandoned all forms of instrument treatments and all but the above, and can heartily recommend it to the profession.—*Med. World.*

LACTIC ACID IN LARYNGEAL TUBERCULOSIS.—Dr. H. Krause, in following up the experimental application of lactic acid as pointed out by Mosetig-Moorhof, who has found it valuable in the local treatment of fungous caries, lupus vulgaris, superficial epithelioma, and papilloma, has made use of the remedy in the local treatment of laryngeal tuberculosis. The cases which he records had previously been under treatment, and a great variety of agents was used without beneficial results. Among the remedies used were iodoformized glycerine, boric acid, carbolic acid, and creasote, either with morphia or cocaine.

The cases in which the pathological condition was treated are fourteen in number, and microscopic examination showed the presence of the baccillus tuberculosis in every instance. The results of the local application of the lactic acid were as follows: Hand-in-hand with the decrease of the infiltration and the scar of the ulcer a diminution of

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pain was noticed, and at the same time diminution of the secretion. The subjective result so far as the larynx is concerned is, that in all the patients, without exception, the condition was markedly improved.

Concerning the return and persistence of the cure after cessation of treatment nothing can be reported, on account of the limited time covered by the observations. Dr. Krause considers, however, that the use of the acid is of certain efficacy in the treatment of this form of tuberculosis, and especially worthy of trial in the light of the failure hitherto experienced in the treatment of this affection of the larynx.

Even in cases in which, owing to far advanced pulmonary tuberculosis, and the general effects of the disease, only a most unfavorable prognosis could be given, the dysphagia accompanying the disease was much diminished by lessening perichondrial œdematous infiltration. The writer further does not hesitate to express a hope that in the least unfavorable cases in which laryngeal tuberculosis has not advanced too far, and the general constitution is well conserved, the use of lactic acid will render it possible to destroy the infiltrated tissue and effect the concurrent cure of the local process. The writer, in conclusion, also suggests the application of lactic acid in other diseases of the mucous membrane of the upper air-passages, among which may be mentioned the diffused swelling and circumscribed thickening accompanying chronic nasal pharyngeal and laryngeal catarrh.—*Berliner klin Wochenschr.*, *July* 21, 1885.—*Medical News*, *Aug.* 22, 1885.—*Canada Lancet.*

Surgery.

Edited by G. FRANK LYDSTON, M.D., 125 State St.

Are Micro-Organisms in Enclosed Cavities, a Danger to Surgical Lesions?[1]—This brief communication is suggestive, and must take the form of a query, since the observations are too limited to allow conclusions except inpossibility. The following clinical histories are at least interesting and instructive.

CASE I.—In the summer of 1883, Mrs. L., aged about 30, consulted me for pain in one limb which had given trouble since the birth

[1] Read in the Section on Surgery and Anatomy at the Thirty-Sixth Annual Meeting of the American Medical Association.

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of her only child, 18 months before. Her general health was excellent, Only a few days after visit, I was informed of her sudden death. She stepped heavily from a horse-car and felt something, as she expressed it, "give way" in her abdomen. Death followed in forty hours.

The autopsy showed a general peritonitis with an effusion of several quarts of milky fluid. The left ovary presented a partly collapsed cyst, size of a pigeon's egg, from a small opening in which had escaped a very little dark-colored semi-fluid material. The cyst was evidently old, with a thick, degenerated, friable wall. I preserved and carefully examined the free abdominal fluid and the contents also of the cyst. The abdominal fluid showed abundant exudation cells and fine granules, amidst which were swimming innumerable large bacilli, in morphological characteristics, not unlike those of anthrax. Abundance of similar bacilli were found in the contents of the cyst. These were cultivated in bulbs and reproduced as a pure culture, unmixed with other bacterial forms. There can be little doubt the cause of death was due to infection from this source.

Case II.—Miss W., aged 40, a patient in my private hospital, with large compound ovarian cyst of rapid growth with thin walls. General health fair. Careful examination of urine gave no evidence of renal disease.

To be Continued.

Books.

Practical Therapeutics. A Compendium of Selected Formulæ and Practical Hints on Treatment. Systematically Arranged, Interleaved and Copiously Indexed. By Edward J. Bermingham, A.M., M.D., New York, Fellow and ex-Vice-President of the American Academy of Medicine, Fellow of the Societe d'Anthropologie de Paris, etc. Editor of "An Encyclopedic Index of Medicine and Surgery," etc. Author of "The Disposal of the Dead—A Plea for Cremation," etc., etc. J. R. Bermingham, Publisher, New York. $3.00.

The above is the title of a most valuable work just issued. The contents are systematically arranged in the following order: General Diseases; Diseases of the Nervous System, Diseases of the Heart, Diseases of the Air-Passages, Diseases of the Digestive System, Diseases of the Urinary System, Diseases of the Male Organs of Generation, Diseases of Women and Diseases of the Skin.

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Numerous formulæ from the leading authorities of the day are given for all the diseases occurring under each of the above heads. The work is handsomely bound and interleaved, contains over four hundred pages, is copiously indexed, and, all things considered, as a means of ready reference in treatment, etc., is ahead of anything we have yet seen, and one which no general practitioner can afford to get along without. H. J. R.

PRACTICAL SURGERY, Including Surgical Dressings, Bandaging, Fractures, Dislocations, Ligature of Arteries, Amputations and Excisions of Wounds and Joints. By J. Ewing Mears, M.D. Lecturer on Practical Surgery in Jefferson Medical College, etc.

In this condensed work of nearly 800 pages, almost every practical point in the art and science of surgery is touched upon, and many of the subjects have been quite exhaustively discussed. The work has evidently been designed for the use of the student, as well as for the busy practitioner who has little time to search through huge volumes of surgical lore for a few practical points. In this book, such information is to be found in a nutshell so to speak. The book is profusely illustrated and the print and paper are as good as the best. It is published by P. Blakiston, Son & Co., Phila. G. F. L.

A TEXT-BOOK OF PHARMACOLOGY, THERAPEUTICS AND MATERIA MEDICA. By T. Lander Brunton, M.D., D.Sc., F.R.S., Fellow of the Royal College of Physicians and Surgeons; Assistant Physician and Lecturer on Materia Medica at St. Bartholomew's Hospital; Examiner in Materia Medica in the University of London, in the Victoria University, and in the Royal College of Physicians, London; Late Examiner in the University of Edinburgh. Adapted to the United States Pharmacopœa, by Francis H. Williams, M.D., Boston, Mass.

This valuable work comprises three sections. The first is devoted to pharmacology and therapeutics. These subjects are treated in a masterly manner, both practical and theoretical, occupying about 390 pages.

The next section embraces the study of general pharmacy, which is discussed briefly, but not disregarding the essentials available to the practitioner and student.

The latter part of the book comprehends the subject of materia medica. The author divides it in organic and inorganic and treats each separately, giving both sufficient latitude and amenity of style to smooth their sharp angles into a pleasing topic.

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To the readers of the "*Practitioner*," the name of Dr. T. Lander Brunton is quite familiar, and its association with numerous and choice articles on therapeutics should more than recommend this book to the medical profession. The first section of this work, principally, contains such an amount of practical and available information, that no studious physician can afford to be without it. C. C. P. S.

MILK ANALYSIS AND INFANT FEEDING. A Practical Treatise on Examination of Human and Cow's Milk, etc., and Directions as to the Diet of Young Infants. By Arthur V. Meigs, M.D., Physician to the Pennsylvania Hospital and to the Children's Hospital; Fellow of the College of Physicians of Philadelphia, etc.

The contents of this little book is, in the great majority, of the knowledge of the profession, for it has been published in the medical journals, which echo the proceedings of the Philadelphia County Medical Society, and the College of Physicians of Philadelphia.

It treats of a subject whose importance, chiefly, as it regards artificial infant feeding, is too well felt by all our confreres, and the practical and systematical manner in which this topic is presented, can not fail to recommend it to all practitioners. C. C. P. S.

A COMPLETE PRONOUNCING MEDICAL DICTIONARY. Embracing the Terminology of Medicine and the Kindred Sciences, with their Signification, Etymology, and Pronunciation. With an Appendix, comprising an Explanation of the Latin Terms and Phrases occurring in Medicine, Anatomy, Pharmacy, etc.; together with the Necessary Directions for writing Latin Prescriptions, etc., etc. By Joseph Thomas, M.D., LL. D., author of the system of Pronunciation in Lippincott's "Pronouncing Gazetteer of the World," and "Pronouncing Dictionary of Biography and Mythology," J. B. Lippincott Co., Publishers, 1886; W. T. Keener, 96 Washington St., Chicago.

Every student when he begins the study of medicine, and every practitioner who tries to keep pace with the rapid advance in medical science, constantly feels the necessity for a reliable lexicon. Should he secure one that satisfactorily meets his requirements, he at once recognizes it as indispensible to his progress While it is very difficult to combine in one volume all the essentials of a complete dictionary, yet Dr. Thomas has succeeded in producing a work that possesses very few faults. It is simply a mine of knowledge, so concisely and methodically arranged that the seeker for information will very seldom be disappointed. One feature of great importance, especially

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to the student, and one which few works of the kind contain, is a complete system of pronunciation. We cordially recommend the book to the profession and particularly to medical students as the best to be obtained.

URINARY AND RENAL DERANGEMENTS AND CALCULOUS DISORDERS. HINTS ON DIAGNOSIS AND TREATMENT. By Lionel S. Beale, M.D., Fellow of the Royal Society, and of the Royal College of Physicians, etc., etc. P. Blakiston, Son & Co., Publishers, 1012 Walnut St., Philadelphia, W. T. Keener, 96 Washington St., Chicago, Ill.

Dr. Beale has condensed within 350 pages a vast fund of useful facts relating to an important and interesting class of disorders. His reputation as a clear and graphic though prolific writer has not been diminished by the publication of the volume before us. There are so many good features in the book worthy of mention that we will be content with saying that it will repay anyone for the time required to read it.

PHYSICIANS VISITING LIST, 1886. (Lindsay and Blackiston's). Thirty-fifth year of its publication. Containing Calendar, List of Poisons and their Antidotes, Dose Tables rewritten in accordance with the Sixth Revision of the U. S. Pharmacopœia, Marshall Hall's Ready Method in Asphyxia, Lists of New Remedies, Sylvester's Method for Producing Artificial Respiration, with Illustrations, Diagram for Diagnosing Diseases of Heart, Lungs, etc. etc. Price for 25 patients weekly, Tucks, pockets, etc., $1.00. For 50 patients weekly, $1.25.

The quality of leather used in binding this list has been again improved, and a superior pencil, with nickel tip, manufactured especially for it, has been added. It has stood the test of time and is still unexcelled.

ANATOMICAL PLATES: Anatomy of the Osseous System. By C. H. Von Klein.

These plates of which the volume devoted to the osseous system is before us, are really excellent, and do both author and publisher great credit. The nomenclature and what little explanatory text has been considered necessary is in Latin, or as the author terms it the "universal medical language." This, however, will not impair the usefulness of the work, even among physicians who are not masters of the language, for the plates, at least, speak for themselves, and the Latin, although more classical is not entirely unlike that with which our elementary works upon anatomy afflict us, so that the average practitioner will have no difficulty in understanding the descriptive text. The typographical errors in the work are comparatively few, and will doubtless be corrected in future additions. The illustrations are quite clearly cut, and the general make-up of the book is excellent.

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Miscellaneous.

We call the attention of physicians to Kidder's Digestylin and also Kidder's Wine of Hypophosphites of Lime and Soda advertised on page 38. These are new preparations. The former is a very palatable wine preparation of pepsin, pancreatine, ptyolin and choleate soda. They claim for it purity and potency. Their process of manufacture avoiding the deleterious effects of chemicals, heat, etc., upon the delicate organic principles entering into its composition, thus retaining their digestive power unimpaired.

The latter is a wine preparation of hypophosphites of lime and soda according to Dr. Churchill's formula. Its prescription is indicated in all cases where the hypophosphides are used. The combination with wine not only tends to aid its tonic action, but masks all the bad taste of the ingredients, and renders it acceptable both to palate and stomach. This preparation they specially recommend for consumption and general debility, when alternated with their celebrated Hydroleine. A sample of either will be sent free to physicians who will address the proprietors, Wm. F. Kidder & Co., 83 John St., New York, and mention the *West. Med. Reporter.*

I have used gallons of Iodia and Bromidia, with the very best results. I prescribe them almost every day and they always give the desired results. T. B. Morrill, M. D.
West Buxton, Me.

VERY IMPORTANT.

Reduction in Price of Anderson's Vaginal Capsules.—By recent improvements in the manufacture of Anderson's Vaginal Capsules, we can now offer them to physicians at 60 cents per box. Corresponding reduction to the trade.

We also take pleasure in announcing that we have greatly improved the Capsules and they are now without doubt the most efficient and convenient means for making local applications in the treatment of female diseases. Circulars on Application. Write for quotations for quantities. Hall & Bailey, Indianapolis, Ind.

J. A. McArthur, M. D.:

Having used your valuable combination of Hypophosphite of Lime and Soda for more than a year, I would like to report to you one case in particular, and then ask a question.

In June last I was called to see a young man aged 18, whose mother and one brother had died of phthisis. I found him suffering from severe pleuritic pain, night sweats, severe, distressing cough and profuse expectoration, characteristic in first stage in phthisis. Tongue coated, pulse 128 to 130, temperature 104 deg. at night. Profuse crepitus in lower half of left lung, dullness on percussion over almost entire left side. Inter-costal depression marked on left mammary, extending backward into left axilary region. No appetite, and general facial expression of rapid emaciation, etc. I began

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the use of your Syrup Hypophos, Comp., and continued it four months, using some other means for night sweats and such other conditions as seemed to require special attention. To-day the young man is about the farm during light work. Appetite excellent; no cough; no night sweats; the wasting of lung substance is arrested, leaving dullness in left lower lung; vesicular murmur gone. The disease is arrested at least, and he has increased in weight forty-three pounds.

I have used the Syrup in five other cases during 1883, with most gratifying results. C. F. BRANCH, M. D., Coventry, Vt.

The Maltine M'f'g. Co., of New York, manufacture an excellent line of Maltine Preparations. They will furnish gratuitously a one-pound bottle of any one of their Maltine Preparations to physicians who will pay the express charges. A good Malt extract is a valuable food, of priceless value in times of emergency. It deserves to stand in the front rank of constructives; and the constructives by their preventive, corrective and curative power, are probably the most widely useful thereapeutical agents that we possess.

Oleo–Chyle is reported to be the only preparation of pure Norwegian Cod Liver Oil and combined with the Hypophosphites that is a digestive agent in itself. It is not an emulsion, but is pure Norwegian Cod Liver Oil, perfectly digested with both Pepsin and Pancreatine, it is therefore immediately assimilated by the most delicate stomach and is in the only condition in which oil can be conveyed by the lacteals into the system to form blood corpuscles. Physicians desiring to test its merits will be furnished a sample free of all expense. Address Geo. W. Laird & Co., 39 Barclay street, New York City.

Codman & Shurtleff, makers and importers of surgical instruments, Boston, Mass., are a most reliable firm. When you want surgical instruments write to them, their prices are most reasonable.

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Christian Jensen & Co., Philadelphia, manufacture the Pallas Syringe, for vaginal and rectal purposes. It is a most perfect and simply constructed syringe for medicating and irrigating the vaginal cavity. Price to physicians, $3.00.

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